



2015 BENEFITS BOOKLET

- MEDICAL/RX • FSA • LIFE/AD&D • DENTAL • VISION •
- DISABILITY • RETIREMENT • LONG-TERM CARE •



Enroll for benefits by November 7, 2014

New coverage effective January 1, 2015

FAST FACTS ABOUT 2015 BENEFIT CHANGES

- **An online benefit system is available to allow you to enroll for 2015 coverage, conduct plan comparisons, and view current coverage.**
 - **Active Employee enrollment:** Go to Intranet>MDC HRIS>Links>MDC Benefits
 - **Retiree enrollment:** Go to mdc.mo.gov>About Us>Careers>Employee Benefits>MDC Benefits
- **Open Enrollment period is being offered for 2015 coverage for Active Salaried employees.** You may enroll in or change medical plans, and/or make changes to your life and/or Accidental Death & Dismemberment (AD&D) coverage. **Retirees**, open enrollment does not apply, however, you may change the type of medical plan you are enrolled in, or reduce your life/AD&D coverage.
- **There is no increase in medical insurance premiums for the 2015 plan year.**
- **A Limited High Deductible Health Plan (LHDHP) is being offered for 2015 to Active Employees. This LHDHP is structured similar to the current HDHP, however, there is no Health Savings Account (HSA) offered with this plan.**
- Ground Ambulance services are covered as an In-Network benefit.
- New tobacco related preventive services are available. For those who use tobacco products, at least two tobacco cessation attempts per year are covered as preventive through a network provider. These items include:
 - Tobacco screening
 - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization
 - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization
- **A non-tobacco user premium discount** is available if subscriber and spouse (if covered on the Plan) are not tobacco users **and** complete the *Tobacco-Free Attestation* online, or by paper, for the 2015 plan year. ***If the Tobacco-Free Attestation is not received each year, you will pay the higher tobacco user premium.***
- Active Employees in the HDHP who wish to enroll or continue with payroll deductions for their HSA in 2015 **must complete** an *HSA Enrollment* online, or by paper, for the new plan year.
- In 2015, new salaried employees' must accept or decline medical coverage online. If an election is not made, **the Limited High Deductible Health Plan will be selected by default.**

Enroll online or submit forms in one of the following ways:

Conservation Employees' Benefits Plan (CEBP)

P.O. Box 507

Jefferson City, MO 65102-0507

Fax: 573-751-9099

Email: HRBenefits@mdc.mo.gov

This guide provides highlights of your benefit plans--it is not a complete, detailed description. See the Conservation Employees' Benefits Plan's (CEBP's) medical insurance Summary Plan Document (SPD) and life insurance document for more information. Websites, including those for vendors responsible for other benefits, should be accessed for detailed information. If there is a difference between this booklet and actual plan document, the plan document is followed. The right is reserved to amend or terminate plans in whole or in part at any time.

2015 Benefit Booklet

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Active Salaried Employees

ENROLLMENT BASICS - Active Salaried Employees

The Conservation Employees' Benefits Plan (CEBP) gives you the opportunity for comprehensive medical, prescription drug, life, accidental death & dismemberment (AD&D) and long-term care (LTC) insurance coverage. You are also eligible to participate in the cafeteria plan, deferred compensation plan, dental and/or vision insurance plan(s), long-term disability insurance plan and retirement plan.

COBRA participants' medical plans (excluding the HSA option) are the same as Active Salaried Employees. Premiums may be found on page 26.

When does my CEBP Coverage Begin?

- ☆ Those signing up due to "**Open Enrollment**" or if you are an **existing salaried employee** and changing your selections during the annual enrollment period, coverage will be effective January 1, 2015.
- ☆ If you are a **new hire**, your insurance coverage begins on either the **1st or 16th of the month following the month you were hired**. For example, John is hired March 1, 2015 and enrolled in CEBP insurance plan before the end of that month. His coverage would be effective April 1, 2015. Carol is hired August 16, 2015 and enrolled in CEBP insurance plan by the 15th of the next month (September). Her coverage would be effective September 16, 2015.

How should I start planning for enrollment?

- ☆ **Review your 2015 benefits**—Learn about your benefit choices and how to enroll.
- ☆ **Complete the decision-making process**--Read sections of the *Benefits Booklet* or view the benefits site to understand the important decisions you need to consider for:
 - Enrollment of an employee or dependent that is not currently a Plan participant but wishes to elect coverage due to "**Open Enrollment**". Provide copies of documents such as birth certificates and/or marriage license.
 - Election of or changes to the medical Plan or tier/level of coverage;
 - Election or changes to your supplemental life insurance, dependent supplemental life insurance or accidental death & dismemberment insurance. **When calculating the cost of your life insurance, please note if you will be changing age brackets.** This will affect the amount;
 - Change in dependent coverage;
 - Enrollment in the cafeteria plan, dental insurance or vision insurance plans.
- ☆ If you would like someone to contact Benefits staff on your behalf or if you have a child over the age of 18 covered under the Plan, a *HIPAA Authorization to Release* must be completed.

What actions do I need to take?

- ☆ **If enrolling in medical coverage due to Open Enrollment:** Enroll online (Intranet>MDC HRIS>Links>MDC Benefits) or return the forms by **November 7, 2014**.
 - *2015 Annual Change Form* (copies of Birth Certificate/Passport and other documentation will be needed)
 - *Tobacco-Free Attestation Form* (if applicable)
 - *MetLife Beneficiary Designation form*
 - *HSA Enrollment/Change Form* (if electing the HDHP)
 - *HSA Beneficiary Change/Spousal Consent Form* (if electing the HDHP)
 - *Terms, Conditions and Signature* (if electing the HDHP)
 - *HIPAA Authorization to Release form* (optional)
- ☆ **Current Members:** Enroll online (Intranet>MDC HRIS>MDC Benefits) or return forms by **November 7, 2014**.
 - *2015 Annual Change Form* (**If you do not wish to make changes you do not need to submit a form; you will be enrolled in the same coverage levels. See below regarding premiums**)
 - *Tobacco Free Attestation* (**must be completed by the subscriber and spouse, if covered by the medical plan, every year for those wishing to receive the non-tobacco user premium**).
 - *MetLife Beneficiary Designation form* (if you did not complete one during 2014 enrollment)
 - *HSA Enrollment/Change Form* (**must be completed every year for those on the HDHP who wish to enroll or continue payroll contributions for the next plan year.**)
- ☆ **New Hires:** Enroll online (Intranet>MDC HRIS>Links>MDC Benefits) **by:**
 - the end of the month if your hire date is the first of that month (i.e. hire date Jan 1, enroll no later than Jan 31st; hire date Feb 1, enroll no later than Feb 28, etc.) OR
 - the 15th of the following month if your hire date is the 16th of the previous month (i.e. hire date Jan 16, enroll no later than Feb 15; hire date Feb 16, enroll no later than Mar 15, etc.)

DECISION 1: MEDICAL INSURANCE
Active Salaried Employees

Plan Comparison Charts can be found on page 23-24.

MAKING YOUR MEDICAL INSURANCE SELECTIONS

Enrollment Deadlines: Current Employees - November 7, 2014

New Employees - End of Month or 15th of month following date of hire

The following provides general information about CEBP medical insurance coverage. Prescription drug coverage is provided as part of your medical plan benefit. Refer to your Summary Plan Document (SPD) for detailed information. Visit the Intranet to find a link to the SPD.

The Commission pays 68% and you pay 32% of the medical plan premium for the Traditional, High Deductible Health Plan, and the Limited High Deductible Health Plan.

Vendors for the Plan are as follows:

HealthLink: contact for network providers, and pre-certifications.

HealthSCOPE Benefits: contact for benefit questions and pre-determinations.

Express Scripts: contact for pharmacy questions.

Benefit Basics

New Salaried Employees:

You are eligible to enroll in the CEBP medical coverage when first hired by the Department. If you were **hired the first of the month, you must enroll by the end of that month**; if you were **hired the 16th of the month, you must enroll by the 15th of the following month**. If you fail to enroll by these deadlines, your next enrollment opportunity is following a qualifying event or during the next open enrollment period. In addition, if you do not decline coverage online, you **will be** enrolled in the Limited High Deductible Health Plan by default.

Existing Salaried Employees:

You may enroll or if you are a current medical plan member, you may make changes for the 2015 Plan Year. If not currently enrolled, you may elect to join the medical, Life, or Accidental Death & Dismemberment plans for 2015.

Eligible Dependents:

You can cover eligible dependents under CEBP medical insurance including:

- ☆ Your spouse.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) until age 26.
- ☆ Unmarried children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof is provided as specified in the SPD. **Please notify Human Resources Benefits Staff prior to their 26th Birthday.**

Pre-Certification: Pre-certification is required for certain services such as: Inpatient Services, Surgeries, Ancillary Services, Durable Medical Equipment, Chemotherapy or Radiation, and Physical Therapy. An additional pre-certification list, requirements and penalties are described in the SPD. The toll free pre-certification number is: 877-284-0102.

Routine Well Care: You can receive routine/well care services paid 100% by the Plan at no additional cost to you. Services that are considered routine well care are:

Routine/Well Care for Adults: *Services are limited to one time per calendar year.*

- Routine physical examination
- Routine gynecological exam
- Routine pap smear screening
- Routine PSA screening
- Routine digital rectal examination (DRE)
- Routine or diagnostic colonoscopy
- Bone Density scan
- Skin Cancer Screen (if performed by a Dermatologist)
- Routine mammogram screening
- All diagnostic laboratory (biometric screening) examinations in connection with the physician office visit including a complete medical history, complete blood count (CBC), blood chemistry, urinalysis, pulmonary function, chest x-ray, EKG and immunizations
- Routine immunizations including:
 - Hepatitis shots
 - Flu shots & Flu mist
 - Pneumovax
 - Tetanus shots
 - Shingles shots

Routine/Well Care for Dependent Children: *Services are limited to one time per calendar year.*

- Routine physical examination
- Routine immunizations
- All diagnostic laboratory examinations in connection with the routine physician office visit, including those screenings mandated by the State of Missouri for newborn screening requirements for potentially treatable or manageable disorders (e.g. Cystic Fibrosis, amino acid disorders, etc.), lead poisoning screenings and newborn hearing screenings.

24-Hour Nurse Hotline: offers access to registered nurses whenever you need them. The nurse will listen to your concerns and help determine if your symptoms can be self-treated, or if they require urgent care or a doctor's visit. The toll-free number is: 866-647-6113.

Lifestyle Management: this is a free tool offered by HealthLink to improve your well-being. The tool offers a private Well-Being Assessment, custom trackers, reminders to track activity, social networks, and recipes. You can choose up to three focus areas for your well-being plan.

Maternity Management: this program is designed to help promote a healthy pregnancy and prevent premature birth. Registered Nurses may be reached 24 hours a day, seven days a week. A "Your Pregnancy Week-by-Week" book and maternity diary are provided, valuable child and safety information given, and post-delivery education and referral is provided. To enroll, please call: 866-647-6113.



Applying Expenses to the Out-of-Pocket Maximum

Expenses applied to the in-network, out-of-pocket maximum will also apply toward the out-of-network, out-of-pocket maximum and vice versa. The following expenses **apply** toward the deductible and out-of-pocket maximum: office visit/specialist copayments, inpatient admission/outpatient surgery fees, and prescription copayments. Penalties, and charges not covered by the Plan do not apply toward the deductible or out-of-pocket maximum.

Tobacco Cessation Program: For those who use tobacco products, at least two tobacco cessation attempts per year will be covered as preventive through a network provider. Coverage includes:

- Tobacco screening
- Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization

If I didn't enroll in CEBP medical insurance when first eligible, can I enroll later?

Yes. You may enroll during Open Enrollment, have a change in family status or a loss of coverage affecting you or an eligible dependent. (Be sure to read the SPD for complete details regarding special enrollment periods.) Change in family status means you get married or have a child (birth or adoption). Loss of coverage means you, or eligible dependent(s), are no longer eligible for coverage under another plan. **In any of these situations, you have only 31 days from the event to enroll in the Plan. Please contact Human Resources Benefits Staff for help!**

Traditional Medical Plan

You have access to a detailed "Schedule of Benefits" in your Summary Plan Document (SPD) on the Conservation Employee Benefits' site or visit www.healthscopebenefits.com. A brief description of the Traditional Medical Plan and prescription drug coverage is also provided below.

Your deductible and copayments (prescription and medical), apply toward your out-of-pocket maximum.

Copayment: You pay a copayment for services you receive from a health care provider, such as an office visit. Copayments continue after you meet your deductible until you reach your out-of-pocket maximum.

- Primary Care Physician (PCP) office visit copay: \$25
- Specialist office visit copay: \$45
- Inpatient Hospitalization copay: \$150 (in addition to deductible/coinsurance)
- Outpatient Surgery copay: \$75 (in addition to deductible/coinsurance)

Deductible: \$1,000 individual/\$2,000 family.

To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining covered family members. Once the family deductible is reached, the deductible is satisfied for all covered family members during the remainder of the benefit period.

Coinsurance: You pay coinsurance of 10%, 20% or 30% of the covered expense (depending on network level of health care provider), AFTER meeting your deductible. Coinsurance payments continue until the out-of-pocket maximum is reached. Below is a listing of how much the Plan will pay for In-network provider tiers after your deductible is met:

Tier I: HMO/Freedom Network Select-90%

Tier II: PPO/Freedom Network-80%



Seeing a Specialist

While you don't need a referral to see a specialist, you may want to seek advice and assistance from your Primary Care Physician (PCP). Remember, you receive the best benefit when you choose a network provider in the HealthLink HMO/Freedom Network Select or HealthLink PPO/Freedom Network. You may call toll free: 800-624-2356 or visit www.healthlink.com.

Out-of-Pocket Maximum: After reaching your out-of-pocket maximum, additional eligible services during the benefits period are covered at 100%.

- **In-network, out-of-pocket maximum (\$2,750 individual/ \$5,500 family):** After meeting the deductible, you pay 10% or 20% coinsurance (depending on network level of health care provider), up to the \$2,750 individual/\$5,500 family maximum. Medical and prescription copayments count toward your out-of-pocket maximum.
- **Out-of-network, out-of-pocket maximum (\$5,500 individual/\$11,000 family):** After meeting your deductible, you pay 30% coinsurance up to the \$5,500 individual/\$11,000 family out-of-pocket maximum.

Plan Comparison Chart: To help you understand differences between the Traditional Medical Plan, the HDHP/HSA, and the Limited HDHP, a comparison chart is located on pages 23-24. ***You may also use the online comparison tool to see which plan works best for you.***

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is provided by Express Scripts, Inc. Prescriptions are required and orders can be filled from either a contracted licensed retail pharmacy (limited to a 30-day supply) or through the mail-order program (90-day supply for maintenance drugs). Detailed information about prescription drug coverage is in the Summary Plan Document (SPD). You can also review the formulary (Plan's preferred drug list) and step therapy drug listings on the CEBP site. A brief description of prescription drug coverage is outlined below.

Drug Categories: Four categories of drugs are covered under the Plan:

Generic--A therapeutically equivalent alternative of a brand-name prescription drug whose patent has expired. These drugs are approved by the Federal Food and Drug Administration (FDA) and are usually available at a fraction of the original brand name cost.

Formulary Brand--A patented prescription drug that appears on the Plan's formulary list.

Non-Formulary Brand--A patented prescription drug that does not appear on the Plan's formulary list.

Specialty--A patented prescription medication that treats chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are injectable and non-injectable drugs which are obtained through Curascripts. You may contact them at: 877-248-1164.

Copayments: Apply toward your deductible and out-of-pocket maximum. If you use a participating pharmacy, you can obtain up to a 30-day maximum supply as follows:

\$15 copay for generic drugs

\$30 copay for formulary brand name drugs

\$50 copay for non-formulary brand name drugs

You can also obtain a 30-day supply of each specialty drug for a 20% coinsurance payment (up to a \$150 maximum).

If you use the mail order service for maintenance drugs, you can obtain a 90-day supply as follows:

\$30 copay for generic drugs

\$60 copay for formulary brand name drugs

\$100 copay for non-formulary brand name drugs

Drug Programs: There are several drug programs to help manage your expenses. Among these programs are:

- **Cardiovascular Disease Program** - Covers services and prescription drugs provided to qualified members with hyperlipidemia and hypertension at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Diabetic Program** - Covers services and prescription drugs provided to diabetic members at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines

established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.

- **\$0 Copay** - Encourages you to go from higher-cost brand name drugs to lower-cost therapeutically equivalent generics by giving you a copayment waiver. If you take one of these medications, you will receive notification from Express Scripts, your pharmacy benefits manager. You could have a six month \$0 copay if, after talking with your physician, you change to a generic drug.
- **Generics Preferred - Physician Choice** - Encourages use of generic prescriptions. If you choose a brand-name drug over a generic drug, even though your doctor has indicated a generic substitution can be used, you will pay the brand copayment plus the difference in cost between the generic and the brand-name drug.
- **Medication Adherence** - Express Scripts uses a multifaceted approach to understanding why members don't take their medications as directed. Various member outreach initiatives are used, including letter interventions, refill reminders and other reminder aids.
- **Prior Authorization** - Monitors disbursement of targeted high-cost medications and medications with the highest potential for inappropriate use. Physicians must obtain prior authorization, based on clinical criteria from Express Scripts, before prescribing one of these medications.
- **Step Therapy** - Directs you to the most cost-effective and safest drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty Step Therapy** – Directs you to the most cost-effective and safest specialty drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty & Pharmacogenomics Prior Authorization** – Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs and explores the ways these variations can be used to predict whether a patient will have a good response to a drug, a bad response to a drug, or no response at all. Express Scripts has developed a list of drugs where a lab result is a vital element in determining if a drug is being used appropriately.
- **Genetic Testing** – Genetic testing is only covered in association with the pharmacogenomics prior authorization program. It is used to determine whether a specific medication would be harmful or ineffective for a given individual before the medication is administered.

High Deductible Health Plan/Health Savings Account (HDHP/HSA)

If you are on Medicare, TRICARE, or enrolled in a traditional plan option,
you are not eligible to participate in the HDHP.

Copayment: There are **no copayments** under the HDHP. This means that until you satisfy the individual or family deductible, **you pay the total cost negotiated by the Plan** for visits to health care providers in-network and the entire fee for services provided by health care professionals who are out-of-network. These expenses can be paid from your HSA (described later), if you choose to participate in the HSA.

Deductible: You have a \$2,500 individual/\$5,000 family deductible for in network services and a \$3,000 individual/\$6,000 family deductible for out-of-network services. In-network deductible amounts apply to out-of-network deductible and vice versa.

To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining covered family members. Once the family deductible is reached, the deductible is satisfied for

all covered family members during the remainder of the benefit period. The in-network out-of-pocket maximum will not exceed \$5,000.

Coinsurance: If services are provided in-network you do not pay coinsurance for covered expenses after you have met your deductible.

Out-of-Pocket Maximum: Your deductible **applies** toward your out-of-pocket maximum.

- **In-network** - There is no additional cost to you for eligible expenses after you have reached your deductible.
- **Out-of-network** - There is an out-of-pocket maximum of \$4,000 for individual and \$8,000 for family. This means you will pay an additional \$1,000 or \$2,000 in addition to your deductible.

Plan Comparison Chart: To help you understand differences between the Traditional Medical Plan and the HDHP/HSA, a comparison chart is located on pages 23-24. ***You may also use the online comparison tool to see which plan works best for you.***

Health Savings Account (HSA)

The HDHP is combined with an HSA feature. HSAs are individually owned bank accounts (meaning you own it) that you can use to pay for current and future eligible medical expenses. Contributions to the account can be made by you and/or your employer on a pre-tax basis. **Funds in the account are yours.** Any remaining balance can be carried over year to year, and an HSA is portable (meaning you can take it with you).

Funding an HSA: There are three ways your HSA can be funded:

- 1) You will receive an enrollment incentive for Plan Year 2015. If you enroll or continue coverage in the HDHP/HSA option, **the CEBP's trust fund will automatically contribute \$250 to your account.** Use this money to pay for current health care expenses, or save the money in your HSA account for future health care expenses.
- 2) You can contribute to your HSA through automatic payroll deductions on a pre-tax basis by completing an HSA Enrollment form (may only make a change one time per month). The one-time enrollment incentive from the CEBP's trust fund is also pre-tax and counts toward your annual maximum contribution. There is an annual maximum amount that can be contributed to your account on a pre-tax basis. **For 2015, you can have \$3,350 contributed on a pre-tax basis if you have individual coverage and \$6,650 if you have family coverage.** The IRS allows something called "catch up contributions" for individuals who are at least 55 years old--An additional \$1,000 in "catch up contributions" is allowed for individual or family coverage.
- 3) If you elect the HDHP/HSA plan option, you can earn additional money for your HSA by participating in certain health/wellness activities called Healthy Reward Incentives. Upon proof of completing the health/wellness activities outlined in the following chart, a deposit the corresponding incentive reward will be made within six weeks into your HSA account if the activity is a covered benefit under the medical plan. If the activity is not a covered benefit it is your responsibility to submit documentation to receive the incentive (ex: weight loss program, sports team, gym membership, dental cleaning, vision exam).

You and your spouse may **each earn up to \$500** in Healthy Reward Incentives if your spouse is enrolled as an eligible dependent in the HDHP/HSA option.

Healthy Reward Incentives

ACTIVITY	INCENTIVE VALUE
Wellness Exam	\$100
Disease Management Program*	\$100
Case Management*	\$100
Biometric Screening*	\$100
Mammogram	\$100
PSA/DRE Exam*	\$100
Colonoscopy	\$100
Weight Loss Program	\$100
Sports Team	\$100
Gym Membership or One Month Workout Log Form	\$100
Dental Cleaning (2x per year)	\$ 50
Routine Vision Exam	\$ 50
Flu Shot	\$ 50
Pneumonia Shot	\$ 50

*refer to the glossary for further explanation

*It is your responsibility to notify HealthSCOPE Benefits with proper documentation of achieving activities not covered by the Plan. Remember, the total limit of incentive per member and spouse is \$500 **each** and the incentive has to have occurred **after** you enrolled in the HSA. **All activities described in the chart are only covered one time per person per year, unless otherwise noted.** Documentation must be submitted to HealthSCOPE Benefits by **January 31st**. To ensure incentive money is credited to the current tax year, HealthSCOPE Benefits must receive documentation by **December 1st**. You may submit your documentation by:*

- Email the information to mdchealthyrewards@healthscopebenefits.com; Log into HealthSCOPE Benefits.com and click on "Submit Healthy Rewards Activities" on right side of screen to access email link;
- Fax the information to: 615-695-8586; or
- Mail to: HealthSCOPE Benefits, Attention Janice Martin, 2875 Elm Hill Pike, Nashville, TN 37214.

If you have questions regarding your HSA such as account balance inquiries, questions on incentives, HSA card requests, etc., please call toll free: 877-385-8775, or you may email questions to flexservices@healthscopebenefits.com. For online account or website issues, please contact HealthSCOPE Benefits toll free: 800-266-9217.

You will find the Workout Log form on the CEBP site or access at www.HealthScopeBenefits.com.

How to Set Up HSA Funds: If you choose the HDHP/HSA option, HealthSCOPE Benefits will open your HSA account with HealthCare Bank. The 2015 one-time enrollment or re-enrollment incentive will be posted to your HSA account by January 1st or one month following your hire date (if a new Plan member).

Healthy Reward Incentives are considered pre-tax contributions and count toward the annual IRS pre-tax contribution maximum amount.



You Don't Have to Use HSA Funds

Each time you have eligible expenses, you decide if you use HSA funds, or other personal funds to pay for the services. If you pay with other funds, HSA money remains in your account and continues to grow.

The HSA balance is yours and can be carried over year to year. It can be used to pay for future health care expenses. If you maintain a \$2,000 minimum balance in your HSA account, you have access to investment options.

If enrolling in the HSA for the first time, **you need to enroll online or complete the following forms to establish your HSA** account: *HSA Enrollment/Change Form*, *HSA Beneficiary Change or Spousal Consent Form*, and *Terms & Conditions Form* (see *Forms tab*). Review the *Custodial Agreement/Disclosure Form* which must be read before signing the *Terms & Conditions Form*. Forms should be returned to Human Resources, Benefits Section, after completion.

You must have money available in your HSA account before using it to pay for eligible medical expenses. The HealthCare Bank will issue a debit card that can be used to pay for eligible expenses from your HSA account. However, you don't have to use the HSA funds. It's your choice whether you pay for services from your HSA account (using your debit card), or pay the providers directly from other personal funds you may have.

Additional HSA Considerations:

- Funds can be used for any qualified medical expense, even if not covered by your HDHP. A complete list of qualified medical expenses can be found at www.irs.gov.
- Funds can be used for over-the-counter medications only if you have a **prescription**.
- Funds not used for qualified expenses are taxed at an income tax rate plus a 20% penalty, unless you are age 65 or over or disabled.
- Funds may be spent on employee (and spouse or dependents, even if they are not enrolled in the medical plan).
- Funds can be used on insurance premiums only when an individual receives COBRA continuation coverage, or receives state or federal unemployment benefits.
- HSAs aren't available to individuals who are also covered through another health plan that is not an HDHP.
- **If you are enrolled in an HSA**, you cannot participate in a Health Care Flexible Spending Account (FSA); however, **you can participate in a Limited Scope Health Care Flexible Spending Account**. This FSA is designed for dental and vision expenses only, but works the same way as a traditional Health Care FSA in every other way. See information pertaining to the Cafeteria Plan on pages 47-48 for additional information.
- Regardless of the medical plan you choose, your premiums can be deducted on a pre-tax basis.
- Contributions to an HSA must end after an individual retires and/or starts receiving Medicare benefits. However, you can continue using the money you've saved in your HSA to pay for eligible medical expenses.

How to Pay for Services: When you enroll in the HDHP/HSA account, you will receive a Health Savings Account card which you can use to pay for services from your HSA account. These funds must be in your account before using it to pay for eligible medical expenses.

When you see a medical provider, please do not pay for medical services until the provider has submitted your claim to HealthLink to obtain plan discounts. Then you will receive an invoice from the medical provider indicating your amount due for the service. At that time, you may choose to use your HSA funds or you may pay out-of-pocket and keep the HSA funds for future use. It is your choice.



Maximum Contribution

The maximum amount you can contribute to your HSA on a pre-tax basis includes the enrollment incentive, any Healthy Reward Incentives you (and your spouse) earn and any automatic payroll contributions you make.

Don't Forget: If you currently have an HSA and want to continue the account, **you must complete an HSA Enrollment/Change Form** (see "Forms section") to elect 2015 pre-tax contributions.

When obtaining prescriptions, please show your medical ID card to the pharmacist to obtain the prescription drug discount. At that time, you may choose to use your HSA funds or you may pay out-of-pocket and keep the HSA funds for future use.

Important Information on Patriot Act Requirements: HealthCare Bank is in compliance with Section 326 of the USA Patriot Act. To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to verify the identity of each person who opens an account. If their identity cannot be verified, they may be required to provide additional documentation, and their HSA may be closed if additional verification is not possible. Confidentiality of the information gathered and used by HealthCare Bank is maintained as required under the Privacy Act.

PRESCRIPTION DRUG COVERAGE

Under the HDHP, you pay the discounted cost (**not a copayment**) for prescription drugs you and your dependents take until you meet your deductible. Cost can be paid from your HSA or by personal funds. Once your deductible is met, your eligible prescriptions are paid by the Plan if obtained through a network pharmacy. Your deductible under the HDHP/HSA includes both medical and pharmacy expenses.

Drug Categories: Four categories of drugs are covered under the Plan:

Generic--A therapeutically equivalent alternative of a brand-name prescription drug whose patent has expired. These drugs are approved by the Federal Food and Drug Administration (FDA) and are usually available at a fraction of the original brand name cost.

Formulary Brand--A patented prescription drug that appears on the Plan's formulary list.

Non-Formulary Brand--A patented prescription drug that does not appear on the Plan's formulary list.

Specialty--A patented prescription medication that treats chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are injectable and non-injectable drugs which are obtained through Curascripts. You may contact them at: 877-248-1164.

Drug Programs: There are several drug programs to help manage your expenses. Among these programs are:

- **Cardiovascular Disease Program** - Covers services and prescription drugs provided to qualified members with hyperlipidemia and hypertension at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Diabetic Program** - Covers services and prescription drugs provided to diabetic members at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Generics Preferred - Physician Choice** - Encourages use of generic prescriptions. If you choose a brand-name drug over a generic drug, even though your doctor has indicated a generic substitution can be used, you will pay the brand copayment plus the difference in cost between the generic and the brand-name drug.
- **Medication Adherence** - Express Scripts uses a multifaceted approach to understanding why members don't take their medications as directed. Various member outreach initiatives are used, including letter interventions, refill reminders and other reminder aids.
- **Prior Authorization** - Monitors disbursement of targeted high-cost medications and medications with the highest potential for inappropriate use. Physicians must obtain prior authorization, based on clinical criteria from Express Scripts, before prescribing one of these medications.

- **Step Therapy** - Directs you to the most cost-effective and safest drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty Step Therapy** – Directs you to the most cost-effective and safest specialty drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty & Pharmacogenomics Prior Authorization** – Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs and explores the ways these variations can be used to predict whether a patient will have a good response to a drug, a bad response to a drug, or no response at all. Express Scripts has developed a list of drugs where a lab result is a vital element in determining if a drug is being used appropriately.
- **Genetic Testing** – Genetic testing is only covered in association with the pharmacogenomics prior authorization program. It is used to determine whether a specific medication would be harmful or ineffective for a given individual before the medication is administered.

Limited High Deductible Health Plan (LHDHP)

Copayment: There are **no copayments** under the Limited HDHP. This means that until you satisfy the individual or family deductible, **you pay the total cost negotiated by the Plan** for visits to health care providers in-network and the entire fee for services provided by health care professionals who are out-of-network.

Deductible: You have a \$2,500 individual/\$5,000 family deductible for in network services and a \$5,000 individual/\$10,000 family deductible for out-of-network services. In-network deductible amounts apply to out-of-network deductible and vice versa.

To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining covered family members.

Coinsurance: You and your dependents pay the discounted cost for medical claims until you meet your deductible, at which point you will pay 30% coinsurance until the out-of-pocket maximum is met. Below is a listing of how much the Plan will pay for In-network provider tiers after your deductible is met:

In-Network: HMO/PPO/Freedom Network Select/Freedom Network-70%

Out-of-Network-50%

Out-of-Pocket Maximum: After reaching your out-of-pocket maximum, additional eligible services during the benefits period are covered at 100%.

- **In-network, out-of-pocket maximum (\$5,000 individual/ \$10,000 family):** After meeting the deductible, you pay 30% coinsurance, up to the \$5,000 individual/\$10,000 family maximum. Medical and prescription copayments count toward your out-of-pocket maximum.
- **Out-of-network, out-of-pocket maximum (\$10,000 individual/\$20,000 family):** After meeting your deductible, you pay 50% coinsurance up to the \$10,000 individual/\$20,000 family out-of-pocket maximum.

Plan Comparison Chart: To help you understand differences between the Traditional Medical Plan, the HDHP/HSA, and the LHDHP, a comparison chart is located on pages 23-24. ***You may also use the online comparison tool to see which plan works best for you.***

PRESCRIPTION DRUG COVERAGE

Under the Limited HDHP, you pay the discounted cost (**not a copayment**) for prescription drugs you and your dependents take until you meet your deductible, at which point you will pay 30% coinsurance until the out-of-pocket maximum is met. Your deductible and out-of-pocket maximum include both medical and pharmacy expenses.

Drug Categories: Four categories of drugs are covered under the Plan:

Generic--A therapeutically equivalent alternative of a brand-name prescription drug whose patent has expired. These drugs are approved by the Federal Food and Drug Administration (FDA) and are usually available at a fraction of the original brand name cost.

Formulary Brand--A patented prescription drug that appears on the Plan's formulary list.

Non-Formulary Brand--A patented prescription drug that does not appear on the Plan's formulary list.

Specialty--A patented prescription medication that treats chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are injectable and non-injectable drugs which are obtained through Curascripts. You may contact them at: 877-248-1164.

Drug Programs: There are several drug programs to help manage your expenses. Among these programs are:

- **Cardiovascular Disease Program** - Covers services and prescription drugs provided to qualified members with hyperlipidemia and hypertension at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Diabetic Program** - Covers services and prescription drugs provided to diabetic members at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Generics Preferred - Physician Choice** - Encourages use of generic prescriptions. If you choose a brand-name drug over a generic drug, even though your doctor has indicated a generic substitution can be used, you will pay the brand copayment plus the difference in cost between the generic and the brand-name drug.
- **Medication Adherence** - Express Scripts uses a multifaceted approach to understanding why members don't take their medications as directed. Various member outreach initiatives are used, including letter interventions, refill reminders and other reminder aids.
- **Prior Authorization** - Monitors disbursement of targeted high-cost medications and medications with the highest potential for inappropriate use. Physicians must obtain prior authorization, based on clinical criteria from Express Scripts, before prescribing one of these medications.
- **Step Therapy** - Directs you to the most cost-effective and safest drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty Step Therapy** - Directs you to the most cost-effective and safest specialty drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty & Pharmacogenomics Prior Authorization** - Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs and explores the ways these variations can be used to predict whether a patient will have a good response to a drug, a bad response to a drug, or

no response at all. Express Scripts has developed a list of drugs where a lab result is a vital element in determining if a drug is being used appropriately.

- **Genetic Testing** – Genetic testing is only covered in association with the pharmacogenomics prior authorization program. It is used to determine whether a specific medication would be harmful or ineffective for a given individual before the medication is administered.

Plan Comparison Chart -- Covered Services

The following chart gives a brief description of out-of-pocket maximums, deductibles, copayments, coinsurance and routine/well care services for the Traditional Medical Plan, the HDHP/HSA and the LHDHP:

	Traditional Plan		High Deductible Health Plan (HDHP)/ Health Savings Account(HSA)	
Covered Service	In-network	Out-of-Network	In-network	Out-of-Network
Plan Description	You pay applicable copayments. In addition, you pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.	You pay the discounted cost of the service until the deductible is met.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.
Deductible	Employee: \$1,000 Family: \$2,000	Employee: \$1,000 Family: \$2,000	Employee: \$2,500 Family: \$5,000	Employee: \$3,000 Family: \$6,000
Deductible amounts met at the in-network level will carry over to the out-of-network level and vice versa.				
Out-of-Pocket Maximum	Employee: \$2,750 Family: \$5,500	Employee: \$5,500 Family: \$11,000	Not Applicable	Employee: \$4,000 Family: \$8,000
Deductible amounts apply to the out-of-pocket maximum.				
Office Visit	Primary Care Physician (PCP) Visit*: \$25 Copay Specialist Office Visit*: \$45 Copay *Copayment applies to all services rendered by same provider in connection with an office visit for which an office visit is billed except for surgery, chemotherapy and radiation therapy.	You pay toward the deductible and/or coinsurance amounts until you reach the out-of-pocket maximum.	You pay the discounted cost of the service until the deductible is met.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.
Copayments - Other	<i>Inpatient Admission:</i> \$150 then Deductible. HMO/FNS: After Deductible, Plan pays 90% PPO/FN: After deductible, Plan pays 80% <i>Outpatient Surgery:</i> \$75, then deductible. HMO/FNS: After deductible, Plan pays 90% PPO/FN: After deductible, Plan pays 80%	<i>Inpatient Admission:</i> \$150 then deductible. After deductible, Plan pays 70% <i>Outpatient Surgery:</i> \$75, then deductible. After deductible, Plan pays 70%	<i>Inpatient Admission:</i> Copayment Not Applicable You pay the discounted cost of the service until the deductible is met. <i>Outpatient Surgery:</i> You pay the discounted cost of the service until the deductible is met	<i>Inpatient Admission:</i> Copayment Not Applicable You pay the full cost of the service until the deductible is met. <i>Outpatient Surgery:</i> You pay the full cost of the service until the deductible is met.
Coinsurance	HMO/FNS: Plan pays 90% PPO/FN: Plan pays 80%	Plan pays 70% after deductible	HMO/PPO/FNS: Not Applicable	Plan pays 70% after deductible
Routine/Well Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
HMO = HealthLink HMO FNS = Freedom Network Select PPO = HealthLink PPO FN = Freedom Network				
You are responsible for charges above the Customary & Reasonable (C&R) rate.				

Plan Comparison Chart -- Covered Services (continued)

	Limited High Deductible Health Plan (HDHP)	
Covered Service	In-network	Out-of-Network
Plan Description	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum .	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum .
Deductible	Employee: \$2,500 Family: \$5,000	Employee: \$5,000 Family: \$10,000
	Deductible amounts met at the in-network level will carry over to the out-of-network level and vice versa.	
Out-of-Pocket Maximum	Employee: \$5,000 Family: \$10,000	Employee: \$10,000 Family: \$20,000
	Deductible amounts apply to the out-of-pocket maximum.	
Office Visit	You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 30% coinsurance until you reach the out-of-pocket maximum.	You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 50% coinsurance until you reach the out-of-pocket maximum.
Copayments - Other	Inpatient Admission: Not Applicable You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 30% coinsurance until you reach the out-of-pocket maximum. Outpatient Surgery: You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 30% coinsurance until you reach the out-of-pocket maximum.	Inpatient Admission: Not Applicable You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 50% coinsurance until you reach the out-of-pocket maximum. Outpatient Surgery: You pay the discounted cost of the service until the deductible is met. Once the deductible is met, you pay 50% coinsurance until you reach the out-of-pocket maximum.
Coinsurance	Plan pays 70% after deductible	Plan pays 50% after deductible
Routine/Well Care	Plan pays 100%	Plan pays 100%
You are responsible for charges above the Customary & Reasonable (C&R) rate.		

PREMIUMS FOR ACTIVE SALARIED EMPLOYEES

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber	\$363.97	\$363.97	\$211.28	\$211.28	\$171.28	\$171.28
Subscriber + Spouse	\$727.95	\$727.95	\$382.56	\$382.56	\$342.56	\$342.56
Subscriber + Child(ren)	\$691.55	\$691.55	\$365.44	\$365.44	\$325.44	\$325.44
Subscriber + Family	\$782.54	\$782.54	\$408.26	\$408.26	\$368.26	\$368.26

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)/with HSA						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber	\$290.30	\$290.30	\$176.60	\$176.60	\$136.60	\$136.60
Subscriber + Spouse	\$580.58	\$580.58	\$313.22	\$313.22	\$273.22	\$273.22
Subscriber + Child(ren)	\$551.56	\$551.56	\$299.56	\$299.56	\$259.56	\$259.56
Subscriber + Family	\$624.14	\$624.14	\$333.70	\$333.70	\$293.70	\$293.70

LIMITED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)/no HSA						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber	\$0	\$234.26	\$0	\$150.24	\$0	\$110.24
Subscriber + Spouse	\$0	\$468.51	\$0	\$260.48	\$0	\$220.48
Subscriber + Child(ren)	\$0	\$445.09	\$0	\$249.46	\$0	\$209.46
Subscriber + Family	\$0	\$503.66	\$0	\$277.00	\$0	\$237.00

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, **you may receive a \$40 per month premium reduction.** Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

Active Traditional Plan COBRA Rates			
Tier	MDC Monthly Contribution	Standard Member Monthly Premium	*Non-Tobacco Use Member Monthly Premium
Subscriber	\$0	\$585.95	\$545.95
Subscriber + Spouse	\$0	\$1,131.93	\$1,091.93
Subscriber + Child(ren)	\$0	\$1,077.32	\$1,037.32
Subscriber + Family	\$0	\$1,213.82	\$1,173.82
Active HDHP Plan COBRA Rates			
Tier	MDC Monthly Contribution	Standard Member Monthly Premium	*Non-Tobacco Use Member Monthly Premium
Subscriber	\$0	\$475.44	\$435.44
Subscriber + Spouse	\$0	\$910.87	\$870.87
Subscriber + Child(ren)	\$0	\$867.33	\$827.33
Subscriber + Family	\$0	\$976.19	\$936.19
Active LIMITED HDHP Plan COBRA Rates			
Tier	MDC Monthly Contribution	Standard Member Monthly Premium	*Non-Tobacco Use Member Monthly Premium
Subscriber	\$0	\$391.39	\$351.39
Subscriber + Spouse	\$0	\$742.77	\$702.77
Subscriber + Child(ren)	\$0	\$707.64	\$667.64
Subscriber + Family	\$0	\$795.47	\$755.47

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, you may receive a **\$40 per month premium reduction**. Both of you must complete the *Tobacco-Free Attestation* form acknowledging you do not use tobacco products to receive the discount.

DECISION 2: LIFE INSURANCE
Active Salaried Employees

MAKING YOUR LIFE INSURANCE COVERAGE SELECTIONS

Enrollment Deadlines: Current Employees - November 7, 2014

New Employees - End of month or 15th of month following date of hire

Eligible Employees and Enrollment:

All salaried employees are CEBP life insurance members. When you are hired by the Department in a salaried position, you are **automatically enrolled for CEBP employee basic and dependent basic life insurance coverage, as appropriate.**

- **New Salaried Employees:** you may elect optional life insurance coverage within the month following your date of hire. As a new hire, you may elect any coverage level without providing medical information.
- **Existing Salaried Employees:** you may elect optional life insurance coverage during open enrollment with an effective date of January 1, 2015. You may increase your coverage by one level without providing medical information. Coverage levels exceeding one level will require an Evidence of Insurability. You may also make changes within 31 days of a change in family status, however; medical information may be required. Effective date of this coverage would be the date the change in family status occurred.

Eligible Dependents:

The following dependents are covered by life insurance:

- ☆ Your spouse.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are under age 26.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof is provided as specified in the SPD.

You must name a beneficiary(ies) for your life insurance benefit. You may change beneficiaries at any time online. Please be sure to keep this information up to date!

Employee Basic Life Insurance: Basic life insurance coverage is provided at no cost to you. You don't have to participate in any other Conservation Employees' Benefits Plan (CEBP) options to receive this **Department-paid benefit.**

The Department automatically provides one time your annual salary in employee basic life insurance coverage. The dollar amount is rounded to the nearest \$1,000. For example, if your annual salary is \$31,776, your basic life insurance is \$32,000. The Department also provides dependent basic life insurance for your spouse (\$1,000), dependent children from live birth to under 6 months (\$250), and eligible dependent children age 6 months to under 26 years old (\$500).

If you are a new salaried employee, your **initial enrollment** allows you to purchase up to an additional 6 times your basic life insurance amount with **no medical information required.** You can change your benefit amount during the annual enrollment period.

Note: Members will be required to provide proof of U.S. citizenship, marital status and other documentation as specified by the SPD and MetLife.

Employee Supplemental Life Insurance: If you wish to purchase supplemental life insurance coverage, you pay the cost of any employee supplemental life insurance (**up to 6 times your basic life insurance amount**) through payroll deduction.

Cost is based on age; rate is charged per \$1,000 of coverage as shown in following chart.

Age	-30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Rate	\$0.035	\$0.062	\$0.080	\$0.096	\$0.150	\$0.230	\$0.430	\$0.660	\$0.890

Example: If your base salary is \$27,300, you are age 32, and want to purchase 3 times your salary of supplemental life insurance the cost would be calculated as follows:

$$\$28,000 \times 3 = \$84,000$$

$$84 \times .062 = \$5.21 \text{ a month or } \$2.61 \text{ per pay period}$$

Dependent Supplemental Life Insurance: You may decide to increase life insurance coverage on eligible dependents. Benefit amounts and cost are listed below:

Option/ Mo. Rate	Dependents Covered	Benefit Amount
Option 1 (\$0.75/Month)	Spouse	\$ 2,500.00
	Child 0-6 Months	\$ 625.00
	Child 6 Months to 26 Years	\$ 1,250.00
Option 2 (\$1.50/Month)	Spouse	\$ 5,000.00
	Child 0-6 Months	\$ 1,250.00
	Child 6 Months to 26 Years	\$ 2,500.00
Option 3 (\$3.00/Month)	Spouse	\$10,000.00
	Child 0-6 Months	\$ 2,500.00
	Child 6 Months to 26 Years	\$ 5,000.00
Option 4 (\$6.00/Month)	Spouse	\$20,000.00
	Child 0-6 Months	\$ 5,000.00
	Child 6 Months to 26 Years	\$10,000.00

Living Benefits Option: If you are diagnosed as terminally ill with a 12-month life expectancy, you may be eligible for payment of a portion of your basic and supplemental life insurance. The remaining amount of your life insurance would go to your beneficiary upon your death. This option does not apply to AD&D benefits.

More than Life Insurance: MetLife offers services in addition to life insurance and AD&D coverage. The following items are available at no additional cost:

Estate Resolution Services	Funeral Planning Guide
Delivering the Promise	Center for Special Needs Planning
Transition Solutions	Travel Assistance
Identity Theft Solutions	

Information regarding these benefits may be found on www.metlife.com under Employee Benefits—Specialty Benefits.

You may elect/change Employee and Dependent supplemental life insurance amounts if you have a *life changing event*. **You must act within 31 days of the date of the family status change.**

***DECISION 3: ACCIDENTAL DEATH & DISMEMBERMENT
(AD&D) INSURANCE
Active Salaried Employees***

MAKING YOUR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

INSURANCE COVERAGE SELECTIONS

Enrollment Deadlines: Current Employees - November 7, 2014
New Employees - End of month or 15th of month following date of hire

Eligible Employees and Enrollment:

When you are hired by the Department in a salaried position, you are automatically enrolled in the CEBP's AD&D insurance plan for employee basic coverage. You have the option to supplement life insurance for you and/or your dependents during the annual enrollment period if you are an existing employee. If you are a new salaried employee, you may elect optional life insurance coverage within the month following your date of hire. You may change your life insurance elections during each annual enrollment period or within 31 days of a change in family status.

Eligible Dependents:

The following dependents can be covered by CEBP's AD&D coverage:

- ☆ Your spouse.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are under age 26.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof is provided as specified in the SPD.

Employee Basic AD&D Insurance:

The **Department pays for basic AD&D insurance** coverage in the amount of one times your annual salary rounded up to the nearest \$1,000. For example, if your annual salary is \$31,776, your AD&D insurance is \$32,000.

AD&D insurance provides benefits for certain injuries or death from an accident. It is in addition to your life insurance coverage, and you can purchase supplemental coverage if you choose.

Employee Supplemental AD&D Insurance:

You can supplement your AD&D insurance in the amounts of \$50,000, \$100,000, \$200,000 or \$300,000 (total family benefit). The actual payout for this benefit can vary for you, your spouse, and dependents depending on the circumstances of the death.

Dependent Supplemental AD&D Insurance: You can carry AD&D insurance on your eligible dependents. The Department does not provide basic family AD&D coverage, so the total cost of family coverage is your responsibility.

Cost of AD&D Insurance:

As shown on the following chart, the monthly cost you pay for employee and dependent AD&D coverage is based on the benefit amount you select and whether you have employee only coverage or family coverage.

Monthly AD&D Rates				
Benefit Amount	\$50,000	\$100,000	\$200,000	\$300,000
Employee	\$1.50	\$3.00	\$6.00	\$9.00
Family	\$2.25	\$4.50	\$9.00	\$13.50

DECISION 4: LONG-TERM CARE (LTC) INSURANCE
Active Salaried Employees

MAKING YOUR LONG-TERM CARE (LTC) INSURANCE COVERAGE SELECTIONS

Enrollment Deadlines: Current Employees – No Specific Deadline
New Employees – No Specific Deadline

The Department offers long-term care (LTC) coverage through CNA Insurance Companies, which gives you the opportunity to purchase coverage on a group basis at affordable premiums. You, your spouse, your parents and parents-in-law, your grandparents and your spouse's grandparents can apply for coverage (as long as under age 80).

Benefits:

Under LTC, you can choose from three different plans: Plan A, Plan B and Plan C. Each plan has a different set of maximums for daily nursing home care benefits, daily community based care benefits and lifetime maximum benefits.

<u>Benefit</u>	<u>Plan A</u>	<u>Plan B</u>	<u>Plan C</u>
Nursing Home Care Daily Benefit Maximum	\$60	\$80	\$100
Community Based Care Daily Benefit Maximum	\$30	\$40	\$50
Lifetime Benefit Maximum	\$120,000	\$160,000	\$200,000

Waiting Period:

Nursing home benefits are payable after you receive 90 days of nursing home care; community based care benefits are payable after you receive 15 days of community based care. A day of the waiting period for nursing home care simultaneously counts toward the waiting period for community based care and vice versa.

Additional Features:

Plans also contain other benefits such as caregiver training, emergency alert systems, respite care, temporary bed holding, waiver of premium and refund of premium upon death.

You may apply for LTC at any time. If applying during the annual enrollment period, complete the *Short Form Application*. At other times during the year, complete the *Long Form Application*. Both applications can be found in the *Long Term Care Insurance Booklet*.

How much does LTC cost?

Premiums are based on your age at the time you enroll for coverage. Rates are shown in the Long-Term Care Insurance booklet (available on the intranet or from HR benefits staff) and you'll note there is an Option 1 and Option 2 rate structure. **Option 2 rates are higher because the option includes the refund of premium feature, while Option 1 does not.** Review the description of this feature to decide if it is right for you.

DECISION 5: DENTAL & VISION INSURANCE
Active Salaried Employees

MAKING YOUR DENTAL INSURANCE COVERAGE SELECTION

Enrollment Deadlines: Current Employees - October 31, 2014

New Employees - Within 31 Days of Hire Date

You have the option of dental insurance coverage through the Missouri Consolidated Health Care Plan (MCHCP). MCHCP has contracted with Delta Dental of Missouri (DDMO) to provide certain diagnostic/preventive dental care and basic/restorative/major dental services. (Orthodontia services are not covered.) You may contact Delta Dental at: 866-737-9802 or visit www.deltadentalmo.com/stateofmo

Eligibility:

You and your eligible dependents may enroll when you are first hired by the Department and during MCHCP's annual open enrollment period.

Premiums, Deductibles, Coinsurance:

You pay a monthly premium for DDMO insurance coverage. A more detailed description of the dental plan, is available on MCHCP's website, www.mchcp.org.

Covered diagnostic/preventive services don't have a deductible or coinsurance; while covered basic/restorative/major services do have set deductibles/coinsurance.

Benefits and Premiums:

Dental Services*

Coverage	Service	You Pay	Note
Coverage A <i>Diagnostic and Preventive</i>	Examinations Prophylaxes (teeth cleaning) Fluoride Bitewing X-rays Sealants	No deductible 0% coinsurance	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
Coverage B <i>Basic and Restorative</i>	Emergency Palliative Treatment Space Maintainers All Other X-rays Minor Restorative Services (fillings) Simple Extractions	\$50/person deductible ¹ 20% coinsurance	X-rays do not apply to the individual plan maximum
Coverage C <i>Major Services</i>	Prosthetic Device Repair All Other Oral Surgery Periodontics Endodontics Prosthetic devices (bridges, dentures) Major Restorative Services (crowns, inlays, onlays)	\$50/person deductible ¹ 50% coinsurance	12-month waiting period for Coverage C services. The waiting period is waived with proof of 12 months of continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's Dental Plan

* Coverage is limited to \$1,000 per person per calendar year benefit period.

1. Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C or combined

Dental Premiums

	Subscriber Only	Subscriber and Spouse	Subscriber and Child(ren)	Subscriber and Family	COBRA Child(ren)
Active Employee	\$23.98	\$47.46	\$49.58	\$83.10	Not Available
Leave of Absence	\$23.98	\$47.46	\$49.58	\$83.10	Not Available
COBRA Subscriber	\$24.45	\$48.72	\$50.56	\$84.76	\$26.11
Retiree, Long-Term Disability, Terminated Vested and Survivor	\$23.98	\$47.46	\$49.58	\$83.10	Not Available

MAKING YOUR VISION INSURANCE COVERAGE SELECTION

Enrollment Deadlines: Current Employees – October 31, 2014

New Employees – Within 31 Days of Hire Date

You have the option of vision insurance coverage through the Missouri Consolidated Health Care Plan (MCHCP). MCHCP has contracted with National Vision Administrators (NVA) to offer certain covered exams, eyeglasses, contact lenses and corrective laser surgery. You may contact NVA at: 877-300-6641 or www.e-nva.com (User Name: mchcp and Password: vision1)

Eligibility:

You and your eligible dependents may enroll when you are first hired by the Department and during MCHCP's annual open enrollment period.

Premiums and Copayments:

You pay a monthly premium for NVA insurance coverage. Rate information, A more detailed description of the vision plan, is available on MCHCP's website, www.mchcp.org.

Benefits and Premiums: There are two vision plans to choose from, a Basic Plan and a Premium Plan. In addition, LASIK discounts are offered. NVA members will pay a maximum amount for corrective laser surgery: Traditional PRK-\$1,500 per eye, Traditional LASIK-\$1,800 per eye, or Custom LASIK-\$2,300 per eye.

Vision Services – Basic Plan

Benefit	Service	Network	Non-network
Exams <i>Once every calendar year</i>	Vision Exam <i>Two annual exams covered for children up to age 18</i>	\$10 copayment	Reimbursed up to \$45
Lenses <i>Once every calendar year One \$25 copayment for lenses Discount applied to all lens options</i>	Single-vision lenses (per pair)	\$25 copayment	Reimbursed up to \$30
	Bifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$50
	Trifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$65
	Lenticular lenses (per pair)	\$25 copayment	Reimbursed up to \$100
	Polycarbonate lenses (per pair) <i>Applies to children up to age 18</i>	100% coverage	Not covered
Frames	<i>Once every 2 calendar years Once every calendar year for children up to age 18</i>	Up to \$125 retail allowance and 20% discount off remaining balance ¹	Reimbursed up to \$70
Contact lenses <i>Once every calendar year in place of eye glass lenses²</i>	Elective <i>If member prefers contacts to glasses</i>	Up to \$125 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance ²	Contact lenses reimbursed up to \$105
	Necessary <i>If medically necessary with prior approval from NVA</i>	Additional costs covered at 100%	Contact lenses reimbursed up to \$210
	Fitting and Evaluation	\$20 copayment for daily contact lenses \$30 copayment for extended contact lenses \$50 copayment for specialty contact lenses	Reimbursed up to \$20 for daily contact lenses or \$30 for extended or specialty contact lenses
Other	Optional Items (cosmetic extras)	Discount applied to all lens options	Not covered

¹ At Walmart or Sam's Club Locations, frame price point is \$55. Discount off remaining balance does not apply.

² At Walmart or Sam's Club Locations, contact lens price point is \$92. Discount off remaining balance does not apply.

Vision Services – Premium Plan

Benefit	Service	Network	Non-network
Exams <i>Once every calendar year</i>	Vision Exam <i>Two annual exams covered for children up to age 18</i>	\$10 copayment	Reimbursed up to \$45
Lenses <i>Once every calendar year</i> <i>One \$25 copayment for lenses</i> <i>Discount applied to all lens options</i>	Single-vision lenses (per pair)	\$25 copayment	Reimbursed up to \$30
	Bifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$50
	Trifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$65
	Lenticular lenses (per pair)	\$25 copayment	Reimbursed up to \$100
	Polycarbonate lenses (per pair) <i>Applies to children up to age 18</i>	100% coverage	Not covered
Standard anti-reflective coating		\$30 copayment	Not covered
Standard progressive multifocal <i>Discount applied to all lens options</i>		\$50 copayment	Not covered
Frames	<i>Once every 2 calendar years</i> <i>Once every calendar year for children up to age 18</i>	Up to \$175 retail allowance and 20% discount off remaining balance ¹	Reimbursed up to \$70
Contact lenses <i>Once every calendar year in place of eye glass lenses</i>	Elective <i>If member prefers contacts to glasses</i>	Up to \$175 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance ²	Contact lenses reimbursed up to \$105
	Necessary <i>If medically necessary with prior approval from NVA</i>	Additional costs covered at 100%	Contact lenses reimbursed up to \$210
	Fitting and Evaluation	\$20 copayment for daily contact lenses \$30 copayment for extended contact lenses \$50 copayment for specialty contact lenses	Reimbursed up to \$20 for daily contact lenses or \$30 for extended or specialty contact lenses
Other	Optional Items (cosmetic extras)	Discount applied to all lens options	Not covered

1. At Walmart or Sam's Club Locations, frame price point is \$77. Discount off remaining balance does not apply.

2. At Walmart or Sam's Club Locations, contact lens price point is \$129. Discount off remaining balance does not apply.

Vision Premiums

	Subscriber Only		Subscriber and Spouse		Subscriber and Child(ren)		Subscriber and Family		COBRA Child(ren)	
Plan Type	Basic	Premium	Basic	Premium	Basic	Premium	Basic	Premium	Basic	Premium
Active Employee	\$3.84	\$4.84	\$7.68	\$9.66	\$11.06	\$13.96	\$15.78	\$19.90	Not Available	
Leave of Absence	\$3.84	\$4.84	\$7.68	\$9.66	\$11.06	\$13.96	\$15.78	\$19.90	Not Available	
COBRA Subscriber	\$3.91	\$4.94	\$7.82	\$9.85	\$11.28	\$14.23	\$16.10	\$20.30	\$7.37	\$9.29
Retiree, Long-Term Disability, Terminated Vested and Survivor	\$4.00	\$5.05	\$8.01	\$10.09	\$11.55	\$14.57	\$16.48	\$20.79	Not Available	

DECISION 6: CAFETERIA PLAN
DEFERRED COMPENSATION
Active Salaried Employees

MAKING YOUR CAFETERIA PLAN SELECTIONS

Enrollment Deadlines: Current Employees – December 1, 2014
New Employees – Within 31 Days of Hire Date

The State of Missouri sponsors a great opportunity for you to **save money by directing part of your pay on a pre-tax basis**. Through the Missouri Cafeteria Plan (MOCafe), expenses for state-sponsored insurance premiums, essential health care, essential dependent care, and parking, mass transit and vanpooling for work can be set aside. The five pre-tax programs have specific guidelines, which you can review at www.mocafe.com. You can also use the Tax Savings Calculator on this website to determine your future cost savings. A general description of how the programs work is described below.

Eligibility:

You may enroll in MOCafe programs when you are first hired by the Department and when MOCafe offers annual enrollment. If you miss enrollment deadlines, you'll have to wait until next year's enrollment period (with the exception of Commuter Benefit Program). If you are a new salaried employee, you must enroll through SEBES at www.sebes.mo.gov.

Pre-Tax Plans:

(1) Premium Only Plan (POP)

All eligible state-sponsored insurance premiums are deducted on a pre-tax basis, unless you actively opt out.

(2) Health Care Flexible Spending Account (FSA)

You can contribute a portion of your pay, pre-tax, for eligible medical expenses (subject to a \$2,500 maximum annual amount). A full list of eligible expenses is available on the website, but the following are examples of expenses that may qualify for reimbursement: medical and dental deductibles and copays, eye exams, physical therapy, and hearing aids.

The amount you decide to contribute is fixed for the entire plan year. Unused funds at the end of the year are forfeited—meaning you don't receive the money back, nor does it rollover into the next MOCafe period! Estimate your expenses carefully and set money aside accordingly. **If you enroll in the Health Care FSA, you are not eligible to enroll in the Limited Scope Health Care FSA.**

(3) Limited Scope Health Care Flexible Spending Account (FSA) ***(You may only elect this FSA option if enrolled in the HDHP/HSA.)***

You can contribute a portion of your pay, pre-tax, for eligible dental and vision expenses (subject to \$2,500 maximum annual amount). **You must be enrolled in an HDHP to utilize this option and cannot be a participant in the traditional health care FSA.** A full list of eligible expenses is available on the website, but the following are examples of expenses that may qualify for reimbursement: eye exams, orthodontia, and eyeglasses.

Money put into this FSA does not count toward the annual HSA contribution amounts. The amount you decide to contribute is fixed for the entire plan year. Unused funds at the end of the year are forfeited—meaning you don't receive the money back, nor does it rollover into the next MOCafe period.

You automatically have your health, dental and vision insurance premiums deducted from your paycheck before federal, state and social security taxes, **unless you opt out.**



IMPORTANT!!

Participation in Health Care FSA May Be Limited

If you participate in the Department's HDHP/HSA, you cannot participate in the MOCafe Health Care FSA.

You can participate in the Limited Scope FSA and the other 3 pre-tax programs.

Estimate your expenses carefully and set money aside accordingly. **If you enroll in the Limited Scope Health Care FSA, you are not eligible to enroll in the Health Care FSA.**

(4) Dependent Care Flexible Spending Account (FSA)

You can contribute a portion of your pay, pre-tax, for qualifying dependent care expenses (subject to a \$5,000 maximum annual amount). Keep in mind, the amount you decide to contribute is typically fixed for the entire plan year. Unused funds at the end of the year are also forfeited—meaning you don't receive the money back nor does it rollover into the next MOCafe period! Estimate your expenses carefully and set money aside accordingly.

(5) Commuter Benefit Program

You can contribute a portion of your pay, pre-tax, for qualifying parking and commuter expenses (subject to a monthly allowance). Unlike the other programs, once enrolled, you do not need to re-enroll during annual enrollment periods. You can also make a change or stop at any time.

The grace period has been extended for the Health Care FSA and the Limited Scope Health Care FSA. Claims can be incurred until March 15th of the year following the end of the plan year. However, if you change plans from the HDHP to a traditional plan or vice versa, claims would need to be incurred during the plan year (January 1 – December 31) for reimbursement. The claim filing deadline remains April 15th.

MAKING YOUR DEFERRED COMPENSATION PLAN SELECTIONS

Enrollment Deadlines: Current Employees - No Specific Deadline
New Employees - No Specific Deadline

The State of Missouri offers the chance to save for retirement with pre-tax dollars. If you visit www.modeferrredcomp.org you'll find tools you can use to build a more financially-sound retirement future. You may also call toll free: 800-392-0925 for additional information.

Contributions:

You decide how much to have automatically deducted from each paycheck, pre-tax, with the option of changing the contribution amount as often as you like or to cancel it completely. There are no federal or state income taxes when you contribute or while your money is invested; when withdrawals are made, the amount is taxed as ordinary income.

Employees Hired On or After 7/1/12: If you are first hired in Missouri State government on 7/1/12 or thereafter, **you are automatically enrolled to contribute 1% of your total salary** to the Deferred Compensation Plan, **unless** you opt out of the program within 30 days of your initial hire date. There is an annual IRS limit to the amount you can defer, but you may be entitled to use "catch-up provisions" to contribute additional funds to deferred comp.

Investment Options:

There is a streamlined investment "lineup" that offers target date funds, a fixed income cash-like investment and a brokerage window. Be sure to speak with your investment advisor regarding options meeting your needs. The Plan charges an annual "flat fee" to each participant for administrative costs and these fees appear as a transaction on the quarterly statement you receive on your account.



Minimum Contribution and Monthly Administrative Fees

The minimum amount you can contribute to deferred comp is \$12.50 for semi-monthly, \$25.00 for monthly payrolls.

When Can I Withdraw Deferred Compensation Funds?

Deferred Comp funds can be distributed when:

- You leave employment from the State of Missouri (terminate or retire)
- You die
- You have reached age 70½ or retire
- Monies being withdrawn were previously rolled over into the deferred comp plan

The IRS actually requires you to begin taking distributions from the Deferred Comp Plan no later than April 1 following the year you turn age 70½. You may also be able to withdraw funds while still in-service, but there are qualifying conditions that must be met.

DECISION 7: RETIREMENT PLAN
Active Salaried Employees

RETIREMENT PROGRAMS

Enrollment Deadlines: Current Employees - Not Applicable
New Employees - Within 31 Days of Hire Date

The retirement program is administered by the Missouri State Employees' Retirement System (MOSERS).

Eligibility:

Your initial hire date in Missouri State government determines the retirement plan under which you are eligible to participate if you meet "vesting" requirements:

- If you were first hired in Missouri State government prior to January 1, 2011, you participate in either MSEP or MSEP 2000 Plans depending on established time frames corresponding to your hire date.
- If you were first hired in Missouri State government effective January 1, 2011 and thereafter, you participate in MSEP 2011.

Vesting requirements for each of these programs is explained in MOSERS website material.

MOSERS retirement plan handbooks are available under www.mosers.org; select the "Members" tab, then click on "Handbooks." You may also call toll free 800-827-1063 if you have questions.

Benefits:

- The Department makes a monthly contribution to MOSERS for employee retirement benefits.
- If you meet eligibility requirements, you receive a monthly retirement benefit for life with potential cost-of-living increases. If you are married, depending on the option you select at retirement, your surviving eligible spouse may receive a lifetime survivor benefit, too.
- Your retirement benefit is based on your total credited service and your highest 36 consecutive months of pay, along with any unused sick leave (every 21 days (168 hours) of unused sick leave is considered one month of creditable service). The state rewards your continued employment by increasing the value of your retirement benefit for each additional year of service. The more service you have and the higher your annual pay, the higher your retirement benefit.
- If you become eligible to retire (normal retirement or early retirement) under a MOSERS retirement plan, it is your responsibility to contact MOSERS to initiate the process. Please contact them within 2 months of your desired retirement date. In addition, HR Benefits staff to assist you with MDC retirement paperwork. Information regarding retirement and a checklist is located at Intranet>Human Resources>Benefits>Retirement.

Remember, if you are a new salaried employee (this is the first time you have worked for any Missouri state agency in a MOSERS eligible position),

- ☆ You must enroll in MOSERS. Go to www.sebes.mo.gov and follow instructions to complete the enrollment process.
- ☆ 4% of your salary will automatically be deducted from your pay as your contribution to your retirement.
- ☆ **Enrollment must be made within the first 5 days of employment to avoid a double deduction from your paycheck.**

- **Effective January 1, 2013, the Commission Contribution toward retiree medical premiums will be based on tenure** or years of service with the State of Missouri. At the time of retirement, employees who have:
 - 25+ years of service receive a 35% Commission Contribution.
 - 20 – 24 years of service receive a 30% Commission Contribution.
 - 15 – 19 years of service receive a 25% Commission Contribution.
 - Vested status up to 14 years of service receive 20% Commission Contribution.

Employees who retired prior to January 1, 2013, continue to receive a 35% Commission Contribution toward premiums.

If you are a new salaried employee, you must enroll through SEBES. Go to www.sebes.mo.gov and follow instructions to complete the enrollment process.

LONG-TERM DISABILITY (LTD)
EMPLOYEE ASSISTANCE PROGRAM (EAP)
Active Salaried Employees

LONG-TERM DISABILITY (LTD) INSURANCE

MDC offers a long-term disability benefit (LTD) to all active employees. It protects members by providing partial income replacement in the event of disability and can help bridge the gap between active employment and retirement.

Eligibility:

Once you are a member of MOSERS, a long-term disability benefit is available, if needed. This is another **employer-paid benefit, provided at no cost to you.**

Benefits:

There are numerous features of the program you can read about by accessing the website. A few of them are listed below:

- 60% replacement of your pre-disability earnings less any deductible income
- Continuation of creditable service toward retirement benefits for each month you receive disability benefits
- Lump sum survivor benefit to your spouse (or children) if you die while receiving LTD benefits

Once approved for LTD benefits, you may continue the CEBP medical, life insurance, and AD&D benefits. The premiums you pay will be at the Retiree rate.

LTD benefits end when you are no longer disabled, are eligible to receive MOSERS retirement benefits, can work but don't accept available employment, begin receiving LTD benefits from another source or you die.

There is a 90-day benefit waiting period before LTD benefits may begin. If you ever need long-term disability benefits, contact a MOSERS benefits counselor at toll free: 800-827-1063 and JoAnn Hanley (Human Resources, 573-522-4115 ext. 3696) for help in navigating through the process.

The MOSERS long-term disability handbook is available under www.mosers.org; select the "Members" tab, then click on "Handbooks."

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Department offers an Employee Assistance Program (EAP) to help employees and their families deal with stress, depression, emotional, marital or family problems, and short-term drug and alcohol problems. Individuals who face these kinds of problems often feel helpless, hopeless and overwhelmed. This short-term counseling benefit may help you and your family in your time of need.

Eligibility:

Salaried employees, their spouses and/or dependent children are eligible immediately upon the employee's hire. You do not have to be enrolled in the medical plan to participate in the EAP program.

Benefits:

You and eligible dependents may each receive up to five (5) counseling sessions per calendar year, which is paid by the Department. The sessions must be conducted with a licensed counselor, psychologist or psychiatrist. You may decide to select a counselor on your own, you may contact HR benefits staff to get help in locating a counselor, or you may ask HR staff to arrange the sessions for you. Contact Stephanie White at 573-522-4115 ext. 3698 or Amanda Rademan at 573-522-4115 ext. 3232 to enroll in the EAP.

Participation in EAP is voluntary and **confidential**. Billing is between the provider and Human Resources and information is maintained securely. Please do not file any claims for EAP services through our medical insurance until you have exhausted your, and/or your dependents five (5) visits.

<i>RETIREES</i>

ENROLLMENT BASICS – Retirees

Who are Retirees & when does coverage begin?

You are eligible to continue coverage if you are a:

- ☆ Retired employee of the MDC and are actively covered under the Plan's benefits at the time of retirement.
- ☆ Retired member of the Conservation Commission.
- ☆ Surviving spouse or dependent actively covered under the Plan's benefits at the time of the retiree/employee death.
- ☆ Employee of the MDC who was approved for a Long Term Disability (LTD) benefit through MOSERS and left employment as a result of the LTD benefit.

How should I start planning for enrollment?

- ☆ **Review your 2015 benefits**--Learn about your benefit choices and how to enroll.
- ☆ **Complete the decision-making process**--Read sections of this *Booklet* to understand the important decisions you need to consider for:
 - Changes to your medical Plan deductible or tier/level;
 - Cancellation of medical, life, or AD&D coverage. You may cancel coverage at any time however you cannot enroll at a later date.
 - Decreasing your supplemental life insurance, dependent supplemental life insurance or accidental death & dismemberment coverage. Please note if you will be changing age brackets. This will affect the amount;
 - Changes in dependent coverage;
 - Continued coverage in the dental insurance or vision insurance plans.
- ☆ You do not need to carry medical coverage in order to maintain life and/or AD&D insurance coverage.
- ☆ If you would like someone to contact Benefits staff on your behalf or if you have a child over the age of 18 covered under the plan, a HIPAA *Authorization to Release* form must be completed.

What action do I need to take?

- ☆ Enroll online (mdc.mo.gov>About Us>Careers>Employee Benefits>MDC Benefits) or return the following forms by **November 7, 2014**:
 - **2015 Annual Change Form** if you do not wish to make changes, you do not need to submit a form; you will be enrolled in the same coverage levels you currently have. See below regarding premiums).
 - **Tobacco Free Attestation** form (must be completed by the subscriber and spouse, if covered by the medical plan, every year for those wishing to receive the non-tobacco user premium discount).
 - HIPAA *Authorization to Release* form (optional)
 - **MetLife Beneficiary Designation** form (if you did not return one during the 2014 Enrollment period)

<p><i>DECISION 1: MEDICAL INSURANCE</i></p> <p><i>Retirees</i></p>
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Plan Comparison Chart can be found on page 73.

MAKING YOUR MEDICAL INSURANCE SELECTIONS

Deadline: November 7, 2014

The following provides general information about CEBP medical insurance coverage. Prescription drug coverage is provided as part of your medical plan benefit. Refer to your Summary Plan Document (SPD) for detailed information. Visit mdc.mo.gov>About Us>Careers>Employee Benefits>MDC Benefits to find the SPD.

COBRA participants medical plans are the same as Retirees' and premiums may be found on page 81.

Our vendors for the Plan are as follow:

HealthLink: contact for network providers, and pre-certifications.

HealthSCOPE Benefits: contact for benefit questions and pre-determinations.

Express Scripts: contact for pharmacy questions.

Benefit Basics

If you are a current medical plan member, you may make changes for the 2015 Plan Year.

Eligible Dependents:

At retirement you may choose to continue to cover any or all of your eligible dependents under CEBP medical insurance including:

- ☆ Your spouse.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) until age 26.
- ☆ Unmarried children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof is provided as specified in the SPD.



Surviving Dependents

If you are covered by CEBP's medical insurance and you die, your surviving dependents may continue their participation if they were already covered under the CEBP's prior to your death. See SPD for additional information.

Pre-Certification: Pre-certification is required for certain services such as: Inpatient Services, Surgeries, Ancillary Services, Durable Medical Equipment, Chemotherapy or Radiation, and Physical Therapy. The pre-certification number is on the back of your medical Plan ID card. An additional pre-certification list, requirements and penalties are described in your SPD. The toll free pre-certification number is: 877-284-0102.

Routine Well Care: You can receive routine/well care services paid 100% by the Plan at no additional cost to you. Services that are considered routine well care are:

Routine/Well Care for Adults: *Services are limited to one time per calendar year*

- Routine physical examination
- Routine gynecological exam
- Routine pap smear screening
- Routine PSA screening
- Routine digital rectal examination (DRE)
- Routine or diagnostic colonoscopy
- Bone Density scan
- Skin Cancer Screen
- Routine mammogram screening
- All diagnostic laboratory (biometric screening) examinations in connection with the physician office visit including a complete medical history, complete blood count (CBC), blood chemistry, urinalysis, pulmonary function, chest x-ray, EKG and immunizations
- Routine immunizations including:

- Hepatitis shots
- Flu shots & Flu mist
- Pneumovax
- Tetanus shots
- Shingles shots

Routine/Well Care for Dependent Children: *Services are limited to one time per calendar year*

- Routine physical examination
- Routine immunizations
- All diagnostic laboratory examinations in connection with the routine physician office visit, including those screenings mandated by the State of Missouri for newborn screening requirements for potentially treatable or manageable disorders (e.g. Cystic Fibrosis, amino acid disorders, etc.), lead poisoning screenings and newborn hearing screenings.

24-Hour Nurse Hotline: offers access to registered nurses whenever you need them. The nurse will listen to your concerns and help determine if your symptoms can be self-treated, or if they require urgent care or a doctor's visit. The toll-free number is: 866-647-6113.

Lifestyle Management: this is a free tool offered by HealthLink to improve your well-being. The tool offers a private Well-Being Assessment, custom trackers, reminders to track activity, social networks, and recipes. You can choose up to three focus areas for your well-being plan.

Maternity Management: this program is designed to help promote a healthy pregnancy and help prevent premature birth. Registered Nurses may be reached 24 hours a day, seven days a week. A "Your Pregnancy Week-by-Week" book and maternity diary are provided, valuable child and safety information given, and post-delivery education and referral is provided. To enroll, please call: 866-647-6113.

Tobacco Cessation Program: For those who use tobacco products, at least two tobacco cessation attempts per year will be covered as preventive through a network provider. Coverage includes:

- Tobacco screening
- four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization

If I didn't enroll in CEBP medical insurance when first eligible, can I enroll later?

As a retiree, if you did not continue coverage at the time of retirement, **you cannot enroll at a later date.** If you are already covered under the Plan and an eligible dependent experiences a change in family status or a loss of insurance coverage, you may enroll the dependent within **31 days** of the event. (Be sure to read the SPD for complete details regarding special enrollment periods.) Please contact Human Resources Benefits Staff for help!

Traditional Medical Plan

You have access to a detailed “Schedule of Benefits” in your Summary Plan Document (SPD). A brief description of the Traditional Medical Plan and prescription drug coverage is also provided below.

Your deductible and copayments (prescription and medical), apply toward your out-of-pocket maximum.

Copayment: If you are not a Medicare eligible member, you pay a copayment for services you receive from a health care provider, such as an office visit. Copayments continue after you meet your deductible until you reach your out-of-pocket maximum.

- Primary Care Physician (PCP) office visit copay: \$25
- Specialist office visit copay: \$45
- Inpatient Hospitalization copay: \$150 (in addition to the deductible/coinsurance)
- Outpatient Surgery copay: \$75 (in addition to the deductible/coinsurance)

Medicare eligible members are not responsible for **office visit** copayments but need to meet Medicare deductibles and the Plan deductibles before the Plan will pay for medical services.

Deductible: \$1,000 individual/\$2,000 family.

To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining covered family members. Once the family deductible is reached, the deductible is satisfied for all covered family members during the remainder of the benefit period.

Coinsurance: You pay coinsurance of 10%, 20% or 30% of the covered expense (depending on network level of health care provider), after meeting your deductible. Coinsurance payments continue until your out-of-pocket maximum is reached. Medicare eligible members pay 20% coinsurance after deductible is met. Below is a listing of how much the Plan will pay for In-network provider tiers after your deductible is met:

Tier I: HMO/Freedom Network Select-90%

Tier II: PPO/Freedom Network-80%

Out-of-Pocket Maximum: After reaching your out-of-pocket maximum, additional eligible services during the benefits period are covered at 100%.

- **In-network, out-of-pocket maximum (\$2,750 individual/\$5,500 family):** After meeting your deductible, you pay 10% or 20% coinsurance (depending on network level of health care provider), up to the \$2,750 individual/\$5,500 family maximum.
- **Out-of-network, out-of-pocket maximum (\$5,500 individual/\$11,000 family):** After meeting your deductible, you pay 30% coinsurance up to the \$5,500 individual/\$11,000 family maximum.
- **Medicare eligible members** pay 20% coinsurance up to the in-network out-of-pocket maximum on all covered services.

Plan Comparison Chart: To help you understand differences between the Traditional Medical Plan and the HDHP, a comparison chart is located on page 73. **You may also use the online comparison tool to see which plan works best for you.**



Applying Expenses to the Out-of-Pocket Maximum

Expenses applied to the in-network, out-of-pocket maximum will also apply toward the out-of-network, out-of-pocket maximum and vice versa. The following expenses **apply** toward the deductible or out-of-pocket maximum: office visit/specialist copayments, inpatient admission/outpatient surgery fees, and prescription copayments. Penalties, and charges not covered by the Plan do not apply toward deductibles or out-of-pocket maximums.



Seeing a Specialist

While you don't need a referral to see a specialist, you may want to seek advice and assistance from your Primary Care Physician (PCP). Remember, if you are not on Medicare, you receive the best benefit when you choose a provider in the HealthLink HMO/ Freedom Network Select or HealthLink PPO/Freedom Network.

PREScription DRUG COVERAGE

Prescription drug coverage is provided by Express Scripts, Inc. Prescriptions are required and orders can be filled from either a contracted licensed retail pharmacy (limited to a 30-day supply) or through the mail-order program (90-day supply for maintenance drugs). Detailed information about prescription drug coverage is in the Summary Plan Document (SPD). You can also review the formulary (Plan's preferred drug list) and step therapy drug listings on the Department's internet site. On the main page go to About Us>Careers>Employee Benefits>MDCBenefits. A brief description of prescription drug coverage is outlined below.

Drug Categories: Four categories of drugs are covered under the Plan:

Generic--A therapeutically equivalent alternative of a brand-name prescription drug whose patent has expired. These drugs are approved by the Federal Food and Drug Administration (FDA) and are usually available at a fraction of the original brand name cost.

Formulary Brand--A patented prescription drug that appears on the Plan's formulary list.

Non-Formulary Brand--A patented prescription drug that does not appear on the Plan's formulary list.

Specialty--A patented prescription medication that treats chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are injectable and non-injectable drugs which are obtained through Curascripts. You may contact them at: 877-248-1164.

Copayments: Apply toward your deductible and out-of-pocket maximum. If you use a participating pharmacy, you can obtain up to a 30-day maximum supply as follows:

- \$15 copay for generic drugs
- \$30 copay for formulary brand name drugs
- \$50 copay for non-formulary brand name drugs

You can also obtain a 30-day supply of each specialty drug for a 20% coinsurance payment (up to a \$150 maximum).

If you use the mail order service for maintenance drugs, you can obtain a 90-day supply as follows:

- \$30 copay for generic drugs
- \$60 copay for formulary brand name drugs
- \$100 copay for non-formulary brand name drugs

Medicare eligible members will receive a separate prescription card.

Drug Programs: There are several drug programs to help manage your expenses. Among these programs are:

- **Cardiovascular Disease Program** - Covers services and prescription drugs provided to qualified members with hyperlipidemia and hypertension at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Diabetic Program** - Covers services and prescription drugs provided to diabetic members at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **\$0 Copay** - Encourages you to go from higher-cost brand name drugs to lower-cost therapeutically equivalent generics by giving you a copayment waiver. If you take one of these medications, you will receive notification from Express Scripts, your pharmacy benefits manager. You could have a six month \$0 copay if, after talking with your physician, you change to a generic drug.

- **Generics Preferred - Physician Choice** - Encourages use of generic prescriptions. If you choose a brand-name drug over a generic drug, even though your doctor has indicated a generic substitution can be used, you will pay the brand copayment plus the difference in cost between the generic and the brand-name drug.
- **Medication Adherence** - Express Scripts uses a multifaceted approach to understanding why members don't take their medications as directed. Various member outreach initiatives are used, including letter interventions, refill reminders and other reminder aids.
- **Prior Authorization** - Monitors disbursement of targeted high-cost medications and medications with the highest potential for inappropriate use. Physicians must obtain prior authorization, based on clinical criteria from Express Scripts, before prescribing one of these medications.
- **Step Therapy** - Directs you to the most cost-effective and safest drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty Step Therapy** – Directs you to the most cost-effective and safest specialty drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty & Pharmacogenomics Prior Authorization** – Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs and explores the ways these variations can be used to predict whether a patient will have a good response to a drug, a bad response to a drug, or no response at all. Express Scripts has developed a list of drugs where a lab result is a vital element in determining if a drug is being used appropriately.
- **Genetic Testing** – Genetic testing is only covered in association with the pharmacogenomics prior authorization program. It is used to determine whether a specific medication would be harmful or ineffective for a given individual before the medication is administered.

High Deductible Health Plan (HDHP)

Copayment: There are **no copayments** under the HDHP. This means that until you satisfy the individual or family deductible, **you pay the total cost negotiated by the Plan** for visits to health care providers in-network and the entire fee for services provided by health care professionals who are out-of-network.

Deductible: You have a \$2,500 individual/\$5,000 family deductible for in network services and a \$3,000 individual/\$6,000 family deductible for out-of-network services. In-network deductible amounts apply to out-of-network deductible and vice versa.

To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining covered family members. Once the family deductible is reached, the deductible is satisfied for all covered family members during the remainder of the benefit period. The in-network out-of-pocket maximum will not exceed \$5,000.

Coinsurance: If services are provided in-network under HealthLink HMO, HealthLink PPO, Freedom Network Select, or Freedom Network you do not pay coinsurance for covered expenses after you have met your deductible.

Out-of-Pocket Maximum: The deductible **applies** toward the out-of-pocket maximum.

- **In-network** - There is no additional cost to you for eligible expenses after you have reached your deductible.

- **Out-of-network** - There is an out-of-pocket maximum of \$4,000 for individual and \$8,000 for family. This means you will pay an additional \$1,000 or \$2,000 in addition to your deductible.

Plan Comparison Chart: To help you understand differences between the Traditional Medical Plan and the HDHP, a comparison chart is located on page 73. **You may also use the online comparison tool to see which plan works best for you.**

If you elect the HDHP plan option, you can earn additional money by participating in certain health/wellness activities called Healthy Reward Incentives. Upon proof of completing the health/wellness activities outlined in the following chart, HealthSCOPE Benefits will apply the corresponding incentive reward directly toward the applicable deductible amount. *If you are not yet eligible for Medicare, you may elect to open a Health Savings Account (HSA) through a bank of your choice.* You and your spouse may each earn up to \$500 in Healthy Reward Incentives if your spouse is enrolled as an eligible dependent in the HDHP option. These incentives will count toward your deductible.

Healthy Reward Incentives

ACTIVITY	INCENTIVE VALUE
Wellness Exam	\$100
Disease Management Program*	\$100
Case Management*	\$100
Biometric Screening*	\$100
Mammogram	\$100
PSA/DRE Exam*	\$100
Colonoscopy	\$100
Weight Loss Program	\$100
Sports Team	\$100
Gym Membership or One Month Workout Log Form	\$100
Dental Cleaning (2x per year)	\$ 50
Routine Vision Exam	\$ 50
Flu Shot	\$ 50
Pneumonia Shot	\$ 50

*refer to the glossary for further explanation

It is your responsibility to notify HealthSCOPE Benefits with proper documentation of achieving activities not covered by the Plan. Remember, the total limit of incentive per member and spouse is \$500 each.

All activities described in the chart are only covered one time per person per year, unless otherwise noted. Documentation must be submitted to HealthSCOPE Benefits by **January 31st**. You may submit your documentation by:

- Email the information to mdchealthyrewards@healthscopebenefits.com; Log into HealthScopeBenefits.com and click on "Submit Healthy Rewards Activities" on right side of screen to access email link;
- Fax the information to: 615-695-8586 or
- Mail to: HealthSCOPE Benefits, Attention: Janice Martin, 2875 Elm Hill Pike, Nashville, TN 37214.

Get savings negotiated by HealthLink regardless of medical option you choose. By using in-network services, you can spend less on medical costs.

PREScription DRUG COVERAGE

Under the HDHP, you pay the discounted cost (**not a copayment**) for prescription drugs you and your dependents take until you meet your deductible. Once your deductible is met, your eligible prescriptions are paid by the Plan if obtained through a network pharmacy. Your deductible under the HDHP includes both medical and pharmacy expenses. **Retirees with Medicare have the same prescription drug coverage as the Traditional Medical Plan. See page 68.**

Drug Categories: Four categories of drugs are covered under the Plan:

Generic--A therapeutically equivalent alternative of a brand-name prescription drug whose patent has expired. These drugs are approved by the Federal Food and Drug Administration (FDA) and are usually available at a fraction of the original brand name cost.

Formulary Brand--A patented prescription drug that appears on the Plan's formulary list.

Non-Formulary Brand--A patented prescription drug that does not appear on the Plan's formulary list.

Specialty--A patented prescription medication that treats chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Specialty medications are injectable and non-injectable drugs which are obtained through Curascripts. You may contact them at: 877-248-1164.

Drug Programs: There are several drug programs to help manage your expenses. Among these programs are:

- **Cardiovascular Disease Program** - Covers services and prescription drugs provided to qualified members with hyperlipidemia and hypertension at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Diabetic Program** - Covers services and prescription drugs provided to diabetic members at minimal or no cost as long as you are utilizing network providers. The member has to follow the guidelines established by the Registered Nurse Health Coach to be able to receive these services. You may contact the Health Coach Nurse at: 800-367-9938.
- **Generics Preferred - Physician Choice** - Encourages use of generic prescriptions. If you choose a brand-name drug over a generic drug, even though your doctor has indicated a generic substitution can be used, you will pay the brand copayment plus the difference in cost between the generic and the brand-name drug.
- **Medication Adherence** - Express Scripts uses a multifaceted approach to understanding why members don't take their medications as directed. Various member outreach initiatives are used, including letter interventions, refill reminders and other reminder aids.
- **Prior Authorization** - Monitors disbursement of targeted high-cost medications and medications with the highest potential for inappropriate use. Physicians must obtain prior authorization, based on clinical criteria from Express Scripts, before prescribing one of these medications.
- **Step Therapy** - Directs you to the most cost-effective and safest drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty Step Therapy** - Directs you to the most cost-effective and safest specialty drug therapy, and progresses to other more costly or risky therapies only if necessary.
- **Specialty & Pharmacogenomics Prior Authorization** - Pharmacogenomics is the study of how an individual's genetic inheritance affects the body's response to drugs and explores the ways these variations

can be used to predict whether a patient will have a good response to a drug, a bad response to a drug, or no response at all. Express Scripts has developed a list of drugs where a lab result is a vital element in determining if a drug is being used appropriately.

- **Genetic Testing** – Genetic testing is only covered in association with the pharmacogenomics prior authorization program. It is used to determine whether a specific medication would be harmful or ineffective for a given individual before the medication is administered.

Plan Comparison Chart -- Covered Services

The following chart gives a brief description of out-of-pocket maximums, deductibles, copayments, coinsurance and routine/well care services for the Traditional Medical Plan and the HDHP. **For Medicare eligible members, copayments do not apply. After meeting the plan deductible, claims are paid at 80% up to the in-network out-of-pocket maximum amount.**

	Traditional Plan		High Deductible Health Plan (HDHP)/Health Savings Account (HSA)	
Plan Description	You pay applicable copayments. In addition, you pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.	You pay the discounted cost of the service until the deductible is met.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.
Deductible	Employee: \$1,000 Family: \$2,000	Employee: \$1,000 Family: \$2,000	Employee: \$2,500 Family: \$5,000	Employee: \$3,000 Family: \$6,000
Deductible amounts met at the in-network level will carry over to the out-of-network level and vice versa.				
Out-of-Pocket Maximum	Employee: \$2,750 Family: \$5,500	Employee: \$5,500 Family: \$11,000	Not Applicable	Employee: \$4,000 Family: \$8,000
Deductible amounts apply to the out-of-pocket maximum.				
Office Visit	Primary Care Physician (PCP) Visit*: \$25 Copay Specialist Office Visit*: \$45 Copay *Copayment applies to all services rendered by same provider in connection with an office visit for which an office visit is billed except for surgery, chemotherapy and radiation therapy.	You pay toward the deductible and/or coinsurance amounts until you reach the out-of-pocket maximum.	You pay the discounted cost of the service until the deductible is met.	You pay the deductible and coinsurance amounts until you reach out-of-pocket maximum.
Copayments - Other	<i>Inpatient Admission:</i> \$150 then Deductible. HMO/FNS: After Deductible, Plan pays 90% PPO/FN: After deductible, Plan pays 80% <i>Outpatient Surgery:</i> \$75, then deductible. HMO/FNS: After deductible, Plan pays 90% PPO/FN: After deductible, Plan pays 80%	<i>Inpatient Admission:</i> \$150 then deductible. After deductible, Plan pays 70% <i>Outpatient Surgery:</i> \$75, then deductible. After deductible, Plan pays 70%	<i>Inpatient Admission:</i> Copayment Not Applicable You pay the discounted cost of the service until the deductible is met. <i>Outpatient Surgery:</i> You pay the discounted cost of the service until the deductible is met.	<i>Inpatient Admission:</i> Copayment Not Applicable You pay the full cost of the service until the deductible is met. <i>Outpatient Surgery:</i> You pay the full cost of the service until the deductible is met.
Coinsurance	HMO/FNS: Plan pays 90% PPO/FN: Plan pays 80%	Plan pays 70% after deductible	Not Applicable	Plan pays 70% after deductible
Routine/Well Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
HMO = HealthLink HMO FNS = Freedom Network Select PPO = HealthLink PPO FN = Freedom Network				
You are responsible for charges above the Customary & Reasonable (C&R) rate.				

PREMIUMS FOR RETIREES

Retired before 1/1/13

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$258.79	\$258.79	\$520.62	\$520.62	\$480.62	\$480.62
Subscriber w/ Medicare	\$106.43	\$106.43	\$237.65	\$237.65	\$197.65	\$197.65
Subscriber + Family w/o Medicare	\$448.25	\$448.25	\$872.45	\$872.45	\$832.45	\$832.45
Subscriber + Family w/ Medicare	\$173.05	\$173.05	\$361.37	\$361.37	\$321.37	\$321.37
Subscriber 1Over/1Under	\$305.65	\$305.65	\$607.63	\$607.63	\$567.63	\$567.63

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$234.70	\$234.70	\$475.86	\$475.86	\$435.86	\$435.86
Subscriber w/ Medicare	\$85.67	\$85.67	\$199.10	\$199.10	\$159.11	\$159.11
Subscriber + Family w/o Medicare	\$401.91	\$401.91	\$786.41	\$786.41	\$746.41	\$746.41
Subscriber + Family w/ Medicare	\$132.38	\$132.38	\$285.85	\$285.85	\$245.85	\$245.85
Subscriber 1Over/1Under	\$252.06	\$252.06	\$508.10	\$508.10	\$468.10	\$468.10

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, you may receive a **\$40 per month premium reduction**. Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

PREMIUMS FOR RETIREES

Retired after 1/1/13 with up to 14 years of State service

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$147.88	\$147.88	\$631.53	\$631.53	\$591.53	\$591.53
Subscriber w/ Medicare	\$60.81	\$60.81	\$283.26	\$283.26	\$243.26	\$243.26
Subscriber + Family w/o Medicare	\$256.14	\$256.14	\$1,064.56	\$1,064.56	\$1,024.56	\$1,024.56
Subscriber + Family w/ Medicare	\$98.88	\$98.88	\$435.54	\$435.54	\$395.54	\$395.54
Subscriber 1Over/1Under	\$174.66	\$174.66	\$738.62	\$738.62	\$698.62	\$698.62

HIGH DEDECTIBLE HEALTH PLAN (HDHP)						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$134.11	\$134.11	\$576.45	\$576.45	\$536.45	\$536.45
Subscriber w/ Medicare	\$48.96	\$48.96	\$235.82	\$235.82	\$195.82	\$195.82
Subscriber + Family w/o Medicare	\$229.66	\$229.66	\$958.66	\$958.66	\$918.66	\$918.66
Subscriber + Family w/ Medicare	\$75.65	\$75.65	\$342.58	\$342.58	\$302.58	\$302.58
Subscriber 1Over/1Under	\$144.03	\$144.03	\$616.13	\$616.13	\$576.13	\$576.13

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, you may receive a **\$40 per month premium reduction**. Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

PREMIUMS FOR RETIREES

Retired after 1/1/13 with 15-19 years of State service

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$184.85	\$184.85	\$594.56	\$594.56	\$554.56	\$554.56
Subscriber w/ Medicare	\$76.02	\$76.02	\$268.05	\$268.05	\$228.05	\$228.05
Subscriber + Family w/o Medicare	\$320.18	\$320.18	\$1,000.52	\$1,000.52	\$960.52	\$960.52
Subscriber + Family w/ Medicare	\$123.61	\$123.61	\$410.81	\$410.81	\$370.81	\$370.81
Subscriber 1Over/1Under	\$218.32	\$218.32	\$694.96	\$694.96	\$654.96	\$654.96

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$167.64	\$167.64	\$542.92	\$542.92	\$502.92	\$502.92
Subscriber w/ Medicare	\$61.20	\$61.20	\$223.58	\$223.58	\$183.58	\$183.58
Subscriber + Family w/o Medicare	\$287.08	\$287.08	\$901.24	\$901.24	\$861.24	\$861.24
Subscriber + Family w/ Medicare	\$94.56	\$94.56	\$323.67	\$323.67	\$283.67	\$283.67
Subscriber 1Over/1Under	\$180.04	\$180.04	\$580.12	\$580.12	\$540.12	\$540.12

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, **you may receive a \$40 per month premium reduction.** Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

PREMIUMS FOR RETIREES

Retired after 1/1/13 with 20-24 years of State service

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$221.82	\$221.82	\$557.59	\$557.59	\$517.59	\$517.59
Subscriber w/ Medicare	\$91.22	\$91.22	\$252.85	\$252.85	\$212.85	\$212.85
Subscriber + Family w/o Medicare	\$384.21	\$384.21	\$936.49	\$936.49	\$896.49	\$896.49
Subscriber + Family w/ Medicare	\$148.33	\$148.33	\$386.09	\$386.09	\$346.09	\$346.09
Subscriber 1Over/1Under	\$261.98	\$261.98	\$651.30	\$651.30	\$611.30	\$611.30

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$201.17	\$201.17	\$509.39	\$509.39	\$469.39	\$469.39
Subscriber w/ Medicare	\$73.43	\$73.43	\$211.35	\$211.35	\$171.35	\$171.35
Subscriber + Family w/o Medicare	\$344.50	\$344.50	\$843.82	\$843.82	\$803.82	\$803.82
Subscriber + Family w/ Medicare	\$113.47	\$113.47	\$304.76	\$304.76	\$264.76	\$264.76
Subscriber 1Over/1Under	\$216.05	\$216.05	\$544.11	\$544.11	\$504.11	\$504.11

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, you may receive a **\$40 per month premium reduction**. Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

PREMIUMS FOR RETIREES

Retired after 1/1/13 with 25 years of State service

TRADITIONAL PLAN						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$258.79	\$258.79	\$520.62	\$520.62	\$480.62	\$480.62
Subscriber w/ Medicare	\$106.43	\$106.43	\$237.65	\$237.65	\$197.65	\$197.65
Subscriber + Family w/o Medicare	\$448.25	\$448.25	\$872.45	\$872.45	\$832.45	\$832.45
Subscriber + Family w/ Medicare	\$173.05	\$173.05	\$361.37	\$361.37	\$321.37	\$321.37
Subscriber 1Over/1Under	\$305.65	\$305.65	\$607.63	\$607.63	\$567.63	\$567.63

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)						
Tier	MDC Monthly Contribution		Standard Member Monthly Premium		*Non-Tobacco Use Member Monthly Premium	
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>
Subscriber w/o Medicare	\$234.70	\$234.70	\$475.86	\$475.86	\$435.86	\$435.86
Subscriber w/ Medicare	\$85.67	\$85.67	\$199.11	\$199.11	\$159.11	\$159.11
Subscriber + Family w/o Medicare	\$401.91	\$401.91	\$786.41	\$786.41	\$746.41	\$746.41
Subscriber + Family w/ Medicare	\$132.38	\$132.38	\$285.85	\$285.85	\$245.85	\$245.85
Subscriber 1Over/1Under	\$252.06	\$252.06	\$508.10	\$508.10	\$468.10	\$468.10

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, you may receive a **\$40 per month premium reduction**. Both of you must complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products to receive the discount. This must be completed annually.

PREMIUMS FOR RETIREES

Retirees who retired under
VPRP 2009-2010

TRADITIONAL PLAN					
Tier	MDC Standard Monthly Premium		MDC *Non-Tobacco Use Monthly Premium		Subscriber Premium
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2015</u>
Subscriber w/o Medicare	\$678.45	\$678.45	\$638.45	\$638.45	\$100.96
Subscriber w/ Medicare	\$302.58	\$302.58	\$262.58	\$262.58	\$41.50
Subscriber + Family w/o Medicare	\$1,145.84	\$1,145.84	\$1,105.84	\$1,105.84	\$174.87
Subscriber + Family w/ Medicare	\$466.91	\$466.91	\$426.91	\$426.91	\$67.51
Subscriber 1Over/1Under	\$818.72	\$818.72	\$778.72	\$778.72	\$94.56

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)					
Tier	MDC Standard Monthly Premium		MDC *Non-Tobacco Use Monthly Premium		Subscriber Premium
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2015</u>
Subscriber w/o Medicare	\$618.99	\$618.99	\$578.99	\$578.99	\$91.56
Subscriber w/ Medicare	\$251.35	\$251.35	\$211.35	\$211.35	\$33.42
Subscriber + Family w/o Medicare	\$1,031.53	\$1,031.53	\$991.53	\$991.53	\$156.79
Subscriber + Family w/ Medicare	\$366.59	\$366.59	\$326.59	\$326.59	\$51.64
Subscriber 1Over/1Under	\$682.18	\$682.18	\$642.18	\$642.18	\$77.98

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, please complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products. The Commission currently pays the extra \$40 in premium if an attestation is not on file. This attestation must be completed annually.

PREMIUMS FOR RETIREES

Retirees who retired under
VPRP 2011

TRADITIONAL PLAN					
Tier	MDC Standard Monthly Premium		MDC *Non-Tobacco Use Monthly Premium		Subscriber Premium
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2015</u>
Subscriber w/o Medicare	\$679.36	\$679.36	\$639.36	\$639.36	\$100.05
Subscriber w/ Medicare	\$298.85	\$298.85	\$258.85	\$258.85	\$45.23
Subscriber + Family w/o Medicare	\$1,130.10	\$1,130.10	\$1,090.10	\$1,090.10	\$190.61
Subscriber + Family w/ Medicare	\$460.84	\$460.84	\$420.84	\$420.84	\$73.58
Subscriber 1Over/1Under	\$801.70	\$801.70	\$761.70	\$761.70	\$111.58

HIGH DEDUCTIBLE HEALTH PLAN					
Tier	MDC Standard Monthly Premium		MDC *Non-Tobacco Use Monthly Premium		Subscriber Premium
	<u>2014</u>	<u>2015</u>	<u>2014</u>	<u>2015</u>	<u>2015</u>
Subscriber w/o Medicare	\$610.75	\$610.75	\$570.75	\$570.75	\$99.80
Subscriber w/ Medicare	\$248.34	\$248.34	\$208.34	\$208.34	\$36.43
Subscriber + Family w/o Medicare	\$1,017.42	\$1,017.42	\$977.42	\$977.42	\$170.90
Subscriber + Family w/ Medicare	\$361.94	\$361.94	\$321.94	\$321.94	\$56.29
Subscriber 1Over/1Under	\$668.15	\$668.15	\$628.15	\$628.15	\$92.01

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, please complete the *Tobacco-Free Attestation* form (located in forms section) or indicate this in your online benefits account, acknowledging you do not use tobacco products. The Commission currently pays the extra \$40 in premium if an attestation is not on file. This attestation must be completed annually.

Retiree Traditional COBRA Rates			
Tier	MDC Contribution	Standard Monthly Premium	*Non-Tobacco Use Monthly Premium
Subscriber w/o Medicare	\$0	\$794.20	\$754.20
Subscriber w/ Medicare	\$0	\$350.15	\$ 310.15
Subscriber + Family w/o Medicare	\$0	\$1,346.32	\$1,306.32
Subscriber + Family w/ Medicare	\$0	\$544.30	\$504.30
Subscriber 1Over/1Under	\$0	\$930.75	\$890.75
Retiree HDHP COBRA			
Tier	MDC Contribution	Standard Monthly Premium	*Non-Tobacco Use Monthly Premium
Subscriber w/o Medicare	\$0	\$723.97	\$683.97
Subscriber w/ Medicare	\$0	\$289.67	\$249.67
Subscriber + Family w/o Medicare	\$0	\$1,211.29	\$1,171.29
Subscriber + Family w/ Medicare	\$0	\$425.79	\$385.79
Subscriber 1Over/1Under	\$0	\$774.56	\$734.56

***Non-Tobacco User Premium Reduction:** If you and your spouse (if on Plan) do not use tobacco products, **you may receive a \$40 per month premium reduction.** Both of you must complete the *Tobacco-Free Attestation* form acknowledging you do not use tobacco products to receive the discount.

DECISION 2: LIFE INSURANCE
Retirees

MAKING YOUR LIFE INSURANCE COVERAGE SELECTIONS

Enrollment Deadline: November 7, 2014

Eligible Employees and Enrollment: When you retire, you have the option of continuing basic and/or supplemental life insurance coverage through the CEBP for yourself and/or your eligible dependents. You may carry the full amount of basic and supplemental life insurance you currently have (up to the maximum amount), but you may not purchase additional life insurance at the time of retirement. You may choose to carry life insurance on yourself in one of two ways:

- **Option 1:** At the time of retirement, you may carry up to \$100,000 of coverage at the rate of \$1.36 per thousand dollars of coverage.
- **Option 2:** At the time of retirement, you may carry up to \$200,000 of coverage at the rate of \$.90 per thousand dollars of coverage. At the age of 65, your life insurance benefit will be reduced by 50% on January 1 of the year following your 65th birthday. When you reach the age of 70, your benefit will reduce by 35%.

You may also choose to continue basic and/or supplemental life for your spouse and eligible dependents. You may decrease or cancel your life insurance elections during each annual enrollment period or when you have a change in family status. However, you cannot increase your life insurance amount after retirement.

If you make changes during the annual enrollment period, the changes are effective January 1, 2015. If you have a change in family status, the effective date of coverage is the date the change in family status occurred.

You must name a beneficiary(ies) for your life insurance benefit. You may change beneficiaries at any time online or by filling out the beneficiary designation form. Please be sure to keep this information up to date!

Eligible Dependents:

The following dependents are covered by life insurance:

- ☆ Your spouse.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are **under age 26**.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof of U.S. Citizenship is provided as specified in the SPD. **Please notify Human Resources Benefits staff prior to their 26th Birthday.**

Note: Members will be required to provide proof of U.S. citizenship, marital status and other documentation as specified by the SPD and MetLife (if not previously provided).

Dependent Supplemental Life Insurance: You may decide to decrease life insurance coverage on eligible dependents. Benefit amounts and cost are listed below:

Option/ Mo. Rate	Dependents Covered	Benefit Amount
Option 1 (\$0.75/Month)	Spouse	\$ 2,500.00
	Child 0-6 Months	\$ 625.00
	Child 6 Months to 26 Years	\$ 1,250.00
Option 2 (\$1.50/Month)	Spouse	\$ 5,000.00
	Child 0-6 Months	\$ 1,250.00
	Child 6 Months to 26 Years	\$ 2,500.00
Option 3 (\$3.00/Month)	Spouse	\$10,000.00
	Child 0-6 Months	\$ 2,500.00
	Child 6 Months to 26 Years	\$ 5,000.00
Option 4 (\$6.00/Month)	Spouse	\$20,000.00
	Child 0-6 Months	\$ 5,000.00
	Child 6 Months to 26 Years	\$10,000.00

Living Benefits Option: If you are diagnosed as terminally ill with a 12-month life expectancy, you may be eligible for payment of a portion of your basic and supplemental life insurance. The remaining amount of your life insurance would go to your beneficiary upon your death. This option does not apply to AD&D benefits.

More than Life Insurance: MetLife offers services in addition to life insurance and AD&D coverage. The following items are available at no additional cost:

- Estate Resolution Services
- Funeral Planning Guide
- Delivering the Promise
- Center for Special Needs Planning
- Transition Solutions
- Travel Assistance
- Identity Theft Solutions

Information regarding these benefits may be found on www.metlife.com under Employee Benefits—Specialty Benefits.

***DECISION 3: ACCIDENTAL DEATH & DISMEMBERMENT
(AD&D) INSURANCE
Retirees***

MAKING YOUR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE COVERAGE SELECTIONS

Enrollment Deadline: November 7, 2014

Eligible Employees and Enrollment:

As a retiree, you have the option of continuing AD&D insurance coverage at the time of retirement. In addition, you may continue supplemental AD&D insurance for your dependents. You may decrease or cancel your AD&D insurance elections during each annual enrollment period or when you have a change in family status.

Eligible Dependents:

The following dependents can be covered by CEBP's AD&D coverage:

- ☆ Your spouse
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are **under age 26**.
- ☆ Unmarried or married children (natural, step, adopted, foster or other children related to you by blood or marriage for whom you have guardianship/custody) who are disabled before the age of 19. These individuals may remain on the Plan indefinitely as long as proof is provided as specified in the SPD.

Retiree Supplemental AD&D Insurance:

You can supplement your AD&D insurance in the amounts of \$50,000, \$100,000, \$200,000, or \$300,000 (total family benefit). The actual payout for this benefit can vary for you, your spouse, and dependents depending on the circumstances of the death.

Cost of AD&D Insurance:

As shown on the following chart, the monthly cost you pay for employee and dependent AD&D coverage is based on the benefit amount you select and whether you have employee only coverage or family coverage.

Monthly AD&D Rates				
Benefit Amount	\$50,000	\$100,000	\$200,000	\$300,000
Employee	\$1.50	\$3.00	\$6.00	\$9.00
Family	\$2.25	\$4.50	\$9.00	\$13.50

DECISION 4: LONG-TERM CARE (LTC) INSURANCE

Retirees

MAKING YOUR LONG-TERM CARE (LTC) INSURANCE COVERAGE SELECTIONS

Enrollment Deadlines: No Specific Deadline

The Department offers long-term care (LTC) coverage through CNA Insurance Companies, which gives you the opportunity to purchase coverage on a group basis at affordable premiums. You, your spouse, your parents and parents-in-law, your grandparents and your spouse's grandparents can apply for coverage (as long as under age 80).

Benefits:

Under LTC, you can choose from 3 different plans: Plan A, Plan B and Plan C. Each plan has a different set of maximums for daily nursing home care benefits, daily community based care benefits and lifetime maximum benefits.

<u>Benefit</u>	<u>Plan A</u>	<u>Plan B</u>	<u>Plan C</u>
Nursing Home Care Daily Benefit Maximum	\$60	\$80	\$100
Community Based Care Daily Benefit Maximum	\$30	\$40	\$50
Lifetime Benefit Maximum	\$120,000	\$160,000	\$200,000

Waiting Period:

Nursing home benefits are payable after you receive 90 days of nursing home care; community based care benefits are payable after you receive 15 days of community based care. A day of the waiting period for nursing home care simultaneously counts toward the waiting period for community based care and vice versa.

Additional Features:

Plans also contain other benefits such as caregiver training, emergency alert systems, respite care, temporary bed holding, waiver of premium and refund of premium upon death.

You may apply for LTC at any time. Complete the *Long Form Application* that can be found in the *Long Term Care Insurance Booklet*.

How much does LTC cost?

Premiums are based on your age at the time you enroll for coverage. Rates are shown in the Long-Term Care Insurance booklet (available from HR benefits staff) and you'll note there is an Option 1 and Option 2 rate structure. **Option 2 rates are higher because the option includes the refund of premium feature, while Option 1 does not.** Review the description of this feature to decide if it is right for you.

DECISION 5: DENTAL & VISION INSURANCE
Retirees

MAKING YOUR DENTAL INSURANCE COVERAGE SELECTION

You have the option to continue dental insurance coverage through the Missouri Consolidated Health Care Plan (MCHCP) if you had dental coverage at the time of retirement. MCHCP has contracted with Delta Dental of Missouri (DDMO) to provide certain diagnostic/preventive dental care and basic/restorative/major dental services. (Orthodontia services are not covered.) You may contact Delta Dental toll free at: 866-737-9802 or visit www.deltadentalmo.com/stateofmo

Premiums, Deductibles, Coinsurance: You pay a monthly premium for DDMO insurance coverage. A more detailed description of the dental plan, is available on MCHCP's website, www.mchcp.org.

Covered diagnostic/preventive services don't have a deductible or coinsurance; while covered basic/restorative/major services do have set deductibles/coinsurance.

Benefits and Premiums:

Dental Services*

Coverage	Service	You Pay	Note
Coverage A <i>Diagnostic and Preventive</i>	Examinations	No deductible	Dental exams, X-rays, cleanings and fluoride treatment do not apply to the individual plan maximum
	Prophylaxes (teeth cleaning)	0% coinsurance	
	Fluoride		
	Bitewing X-rays		
	Sealants		
Coverage B <i>Basic and Restorative</i>	Emergency Palliative Treatment	\$50/person deductible ¹	X-rays do not apply to the individual plan maximum
	Space Maintainers		
	All Other X-rays	20% coinsurance	
	Minor Restorative Services (fillings)		
	Simple Extractions		
Coverage C <i>Major Services</i>	Prosthetic Device Repair	\$50/person deductible ¹	12-month waiting period for Coverage C services. The waiting period is waived with proof of 12 months of continuous dental coverage for major services immediately prior to the effective date of coverage in MCHCP's Dental Plan
	All Other Oral Surgery		
	Periodontics	50% coinsurance	
	Endodontics		
	Prosthetic devices (bridges, dentures)		
	Major Restorative Services (crowns, inlays, onlays)		

* Coverage is limited to \$1,000 per person per calendar year benefit period.

1. Coinsurance amounts apply after the \$50 individual deductible is met under either Coverage B or C or combined

Dental Premiums

	Subscriber Only	Subscriber and Spouse	Subscriber and Child(ren)	Subscriber and Family	COBRA Child(ren)
Active Employee	\$23.98	\$47.46	\$49.58	\$83.10	Not Available
Leave of Absence	\$23.98	\$47.46	\$49.58	\$83.10	Not Available
COBRA Subscriber	\$24.45	\$48.72	\$50.56	\$84.76	\$26.11
Retiree, Long-Term Disability, Terminated Vested and Survivor	\$23.98	\$47.46	\$49.58	\$83.10	Not Available

MAKING YOUR VISION INSURANCE COVERAGE SELECTION

You have the option of continuing vision insurance coverage through the Missouri Consolidated Health Care Plan (MCHCP) if you had vision coverage at the time of retirement. MCHCP has contracted with National Vision Administrators (NVA) to offer certain covered exams, eyeglasses, contact lenses and corrective laser surgery. You may contact NVA toll free at: 877-300-6641 or www.e-nva.com (User Name: mchcp and Password: vision1)

Premiums and Copayments: You pay a monthly premium for NVA insurance coverage. A more detailed description of the vision plan, is available on MCHCP's website, www.mchcp.org.

Benefits and Premiums: In 2015 there are two vision plans to choose from, a Basic Plan and a Premium Plan. In addition, LASIK discounts are offered. NVA members will pay a maximum amount for corrective laser surgery: Traditional PRK-\$1,500 per eye, Traditional LASIK-\$1,800 per eye, or Custom LASIK-\$2,300 per eye.

Vision Services – Basic Plan

Benefit	Service	Network	Non-network
Exams <i>Once every calendar year</i>	Vision Exam <i>Two annual exams covered for children up to age 18</i>	\$10 copayment	Reimbursed up to \$45
Lenses <i>Once every calendar year One \$25 copayment for lenses Discount applied to all lens options</i>	Single-vision lenses (per pair)	\$25 copayment	Reimbursed up to \$30
	Bifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$50
	Trifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$65
	Lenticular lenses (per pair)	\$25 copayment	Reimbursed up to \$100
	Polycarbonate lenses (per pair) <i>Applies to children up to age 18</i>	100% coverage	Not covered
Frames	<i>Once every 2 calendar years Once every calendar year for children up to age 18</i>	Up to \$125 retail allowance and 20% discount off remaining balance ¹	Reimbursed up to \$70
Contact lenses <i>Once every calendar year in place of eye glass lenses</i>	Elective <i>If member prefers contacts to glasses</i>	Up to \$125 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance ²	Contact lenses reimbursed up to \$105
	Necessary <i>If medically necessary with prior approval from NVA</i>	Additional costs covered at 100%	Contact lenses reimbursed up to \$210
	Fitting and Evaluation	\$20 copayment for daily contact lenses \$30 copayment for extended contact lenses \$50 copayment for specialty contact lenses	Reimbursed up to \$20 for daily contact lenses or \$30 for extended or specialty contact lenses
Other	Optional Items (cosmetic extras)	Discount applied to all lens options	Not covered

¹ At Walmart or Sam's Club Locations, frame price point is \$55. Discount off remaining balance does not apply.

² At Walmart or Sam's Club Locations, contact lens price point is \$92. Discount off remaining balance does not apply.

Vision Services – Premium Plan

Benefit	Service	Network	Non-network
Exams <i>Once every calendar year</i>	Vision Exam <i>Two annual exams covered for children up to age 18</i>	\$10 copayment	Reimbursed up to \$45
Lenses <i>Once every calendar year</i> <i>One \$25 copayment for lenses</i> <i>Discount applied to all lens options</i>	Single-vision lenses (per pair)	\$25 copayment	Reimbursed up to \$30
	Bifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$50
	Trifocal lenses (per pair)	\$25 copayment	Reimbursed up to \$65
	Lenticular lenses (per pair)	\$25 copayment	Reimbursed up to \$100
	Polycarbonate lenses (per pair) <i>Applies to children up to age 18</i>	100% coverage	Not covered
Standard anti-reflective coating		\$30 copayment	Not covered
Standard progressive multifocal <i>Discount applied to all lens options</i>		\$50 copayment	Not covered
Frames	<i>Once every 2 calendar years</i> <i>Once every calendar year for children up to age 18</i>	Up to \$175 retail allowance and 20% discount off remaining balance ¹	Reimbursed up to \$70
Contact lenses <i>Once every calendar year in place of eye glass lenses</i>	Elective <i>If member prefers contacts to glasses</i>	Up to \$175 retail allowance and 15% discount off conventional or 10% discount off disposable remaining balance ²	Contact lenses reimbursed up to \$105
	Necessary <i>If medically necessary with prior approval from NVA</i>	Additional costs covered at 100%	Contact lenses reimbursed up to \$210
	Fitting and Evaluation	\$20 copayment for daily contact lenses \$30 copayment for extended contact lenses \$50 copayment for specialty contact lenses	Reimbursed up to \$20 for daily contact lenses or \$30 for extended or specialty contact lenses
Other	Optional Items (cosmetic extras)	Discount applied to all lens options	Not covered

¹ At Walmart or Sam's Club Locations, frame price point is \$77. Discount off remaining balance does not apply.

² At Walmart or Sam's Club Locations, contact lens price point is \$129. Discount off remaining balance does not apply.

Vision Premiums

Plan Type	Subscriber Only		Subscriber and Spouse		Subscriber and Child(ren)		Subscriber and Family		COBRA Child(ren)	
	Basic	Premium	Basic	Premium	Basic	Premium	Basic	Premium	Basic	Premium
Active Employee	\$3.84	\$4.84	\$7.68	\$9.66	\$11.06	\$13.96	\$15.78	\$19.90	Not Available	
Leave of Absence	\$3.84	\$4.84	\$7.68	\$9.66	\$11.06	\$13.96	\$15.78	\$19.90	Not Available	
COBRA Subscriber	\$3.91	\$4.94	\$7.82	\$9.85	\$11.28	\$14.23	\$16.10	\$20.30	\$7.37	\$9.29
Retiree, Long-Term Disability, Terminated Vested and Survivor	\$4.00	\$5.05	\$8.01	\$10.09	\$11.55	\$14.57	\$16.48	\$20.79	Not Available	

FORMS

Enrollment may be completed online by following the links below:

Active Employees: Intranet>MDC HRIS>Links>MDC Benefits

Retirees: mdc.mo.gov>About Us>Careers>Employee Benefits>MDC Benefits

or

Please submit forms to:

- HRBenefits@mdc.mo.gov
- Fax: 573-751-9099
- CEBP, PO Box 507, Jefferson City, MO 65102-0507



Conservation Employees' Benefits Plan

Tobacco-Free Attestation

Note: This Attestation must be filled out by the subscriber and spouse (if both are enrolled in the medical insurance plan) **each plan year** in order to receive the discounted monthly insurance premiums. Please return to Human Resources Division/Benefits Section/Central Office.

Please check the appropriate box: ☐ Active Employee ☐ Retiree ☐ 2014 ☐ 2015

Subscriber Information & Attestation

Name (Last, First, Middle Initial):	Social Security Number (last 4): XXX-XX-____
Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code	
I will not use tobacco products. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.	
I understand that providing false information may subject me to repay the discount I received, and may also subject me to fines and/or discipline.	
Signature:	Date (MM/DD/YYYY):

This Attestation will not be completed unless signed by the subscriber whose name appears above.

Spouse Information & Attestation (if on the medical insurance plan)

Name (Last, First, Middle Initial):	Social Security Number: (last 4): XXX-XX-____
Address:	Date of Birth (MM/DD/YYYY):
City, State, Zip Code	
I will not use tobacco products. If I begin using tobacco products, I will notify Human Resources Division by phone, fax or mail immediately to adjust my monthly premium beginning with the next pay cycle.	
I understand that providing false information may subject me to repay the discount I received, and may also subject me to fines and/or discipline.	
Signature:	Date (MM/DD/YYYY):

This Attestation will not be completed unless signed by the spouse whose name appears above.

APPLICANT INFORMATION

EMPLOYER		HIRE DATE	PLAN EFFECTIVE DATE	<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> 2015 Plan Year
				<input type="checkbox"/> CHANGE	<input type="checkbox"/> 2014 Plan Year
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)			DATE OF BIRTH	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
PHONE NUMBER		EMAIL ADDRESS			
GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	MOTHER'S MAIDEN NAME		MARITAL STATUS <input type="checkbox"/> Unmarried <input type="checkbox"/> Married	COVERAGE LEVEL <input type="checkbox"/> Single <input type="checkbox"/> Family	
PREFERRED REIMBURSEMENT METHOD <input type="checkbox"/> Check <input type="checkbox"/> Direct Deposit			PAYROLL FREQUENCY <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly		
BANK NAME (IF DIRECT DEPOSIT IS SELECTED)			ACCOUNT NUMBER	ROUTING/TRANSIT NUMBER	
CITY			STATE	ACCOUNT TYPE <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
DEBIT CARD <input type="checkbox"/> Yes <input type="checkbox"/> No	SPOUSE DEBIT CARD <input type="checkbox"/> Yes <input type="checkbox"/> No	SPOUSE NAME		SPOUSE DATE OF BIRTH	

HEALTH SAVINGS ACCOUNT ELECTION

MY PAYROLL CONTRIBUTION IS TO BE IN THE AMOUNT OF: \$ _____ PER PAYROLL DEDUCTION			FOR A SPECIAL PAYROLL DEDUCTION ARRANGEMENT, PLEASE EXPLAIN: Note: This election remains in effect until the end of the plan year unless changed. Changes may be made online or by submitting a new HSA Enrollment Information form. A new election must be made at annual enrollment for the next plan year.
2015	Individual Coverage	Family Coverage	
Annual Maximum	\$3,350	\$6,650	
Catch-up Contribution (55 or older)	\$1,000	\$1,000	

ACKNOWLEDGEMENT AND SIGNATURE

This enrollment form is to open or change an existing Health Savings Account that is used to accumulate assets for the payment of qualified healthcare expenses. Your Health Savings Account is your financial asset even if you change employers or health plans. To open a Health Savings Account you must meet three criteria: 1) You must be covered by a qualified high deductible health plan, 2) You cannot be covered by another health plan, including Medicare and 3) You cannot be claimed as a dependent on another individual's tax return.

By signing my name below, I understand and acknowledge that:

I have read and understand the accompanying HSA Custodial Agreement and Disclosure Statement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

- determining that I am eligible to make contributions to an HSA for each year I make a contribution;
- ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;
- the tax consequences of any contributions (including rollover contributions) or distributions; and
- seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

EMPLOYEE SIGNATURE _____

DATE _____

PLEASE SEND COMPLETED FORM TO:

MAIL: Conservation Employees' Benefits Plan
P.O. Box 507
Jefferson City, MO 65102-0507

E-MAIL: HRBenefits@mdc.mo.gov

FAX: 1-573-751-9099



HSA BENEFICIARY CHANGE/SPOUSAL CONSENT FORM

Instructions

1. Use this form to designate or change your beneficiary. If you are married in common law or in a community property or marital property state, you must designate your spouse as your Primary Beneficiary. If you wish to designate someone other than your spouse, your spouse must agree by signing in the Spousal Consent section. Your spouse's signature must be notarized.
2. Forward completed form to: **HealthSCOPE Benefits, Inc. (TPA) at:**
Conservation Employees Benefits Plan
P.O. Box 507
Jefferson City, MO 65102-0507
3. For any questions regarding changing your beneficiary, please call **(877) 385-8775**.

Accountholder Information

Last Name	First Name	Middle Initial
<hr/>		
Social Security Number	Employee ID and Employer (if applicable)	
<hr/>		
Telephone Number	E-mail Address	
<hr/>		

Beneficiary Designation

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA, and I hereby revoke all prior death beneficiary designations made by me. Share percentages must equal 100% for primary and 100% for contingent.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.	<div></div>	<div></div>	<div></div>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<div></div>
2.	<div></div>	<div></div>	<div></div>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<div></div>
3.	<div></div>	<div></div>	<div></div>	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<div></div>

Spousal Consent (for HSA Accountholders married in common law or in a community property or marital property states)

- ☐ I am not married and I understand that if I become married in the future, I must complete a new HSA Beneficiary Change/Spousal Consent Form.
- ☐ I am married and I understand that if I choose to designate a primary death beneficiary other than my spouse, my spouse must agree to the designation by signing below. My spouse's signature must be notarized.

<div></div> Signature of Spouse	Subscribed and sworn to before me this _____ day of _____, 20____
<div></div> Date	<div></div> Notary Public

Signature

I certify that I am the HSA Accountholder or an individual authorized to execute this transaction. I assume full responsibility for this transaction and will not hold TPA or Healthcare Bank liable for any adverse consequences that may result. I have not received any tax or legal advice from TPA or Healthcare Bank and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws.

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary survives me, the contingent death beneficiary shall acquire the designated share of my HSA.

I understand that if I am married and my residence is in a community or marital property state, or if I am transferring property to this HSA that I acquired while married and residing in a community or marital property state, my spouse may have a community or marital property interest in contributions to and earnings in this HSA, whatever the source. This community property interest may be released by a properly executed consent. I understand that I may wish to consult with legal counsel to ensure that my designation is proper. I understand that if I designate my spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of my marriage will automatically revoke such designation.

<div></div> Signature of HSA Accountholder	<div></div> Date
---	---------------------

Name: _____ SSN: _____

Terms, Conditions and Signature

Important Information Regarding Patriot Act Requirements

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. I understand that when I open my HSA, I will be asked for my name, address, date of birth, and other information that will allow my custodian to identify me. I understand that I may also be asked to present my driver's license or other identifying documents. I understand that my identity will be verified through the use of a database maintained by a third party. If my identity cannot be verified, I understand that I may be required to provide additional information, and that my HSA may be closed if additional verification is not possible. Upon such closure, funds deposited in my HSA will be returned to me, less any fees, expenses or taxes chargeable against my HSA, or penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in my HSA account. As custodian, Healthcare Bank, a division of State Bank & Trust, shall not be liable for any tax consequences I may incur as a result of the transfer or distribution of my assets.

Important Information Regarding Death Beneficiary Information

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

I understand that if I am married and reside in a community or marital property state, or if I am transferring property to this HSA that I acquired while married and residing in any of those states, my spouse may have a community or marital property interest in contributions to and earnings in this HSA, whatever the source. This community property interest may be released by a properly executed consent. The enrollment form contains a release for this purpose. I understand that I may wish to consult with legal counsel to ensure that my designation is proper.

I understand that if I designate my spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of my marriage will automatically revoke such designation.

Important Information Regarding My Account Summary

I understand that account statements are made available electronically and may be viewed at any time by logging into my account at <http://www.healthscopebenefits.com>. For an additional fee, the HSA Administrator that I identify as my Designated Representative may send paper statements to my address by U.S. mail. I will check the box below if I also wish to receive paper statements by U.S. Mail.

- ☐ I wish to receive paper statements by U.S. Mail. By electing this option I acknowledge that an additional fee may apply. The amount of the fee and frequency of the paper statements are set forth on the attached fee schedule. Paper account statements are limited to current balances, contributions and distributions.

Important Information Regarding My HSA Investment Account

I understand that once I have accumulated at least \$2,000 in cash in my HSA, the balance of my account above \$2,000 will automatically be invested in an interest-bearing, FDIC-insured account. I may also choose to change my allocation choices and select from the TPA's list of mutual funds for the investment of HSA assets in excess of \$2,000. The HSA Investment Account is exclusively available online at <http://www.healthscopebenefits.com>. An email address must be included in enrollment or it will not be available. All investment transactions in the HSA Investment Account will be initiated and conducted electronically or by telephone. All required disclosures of investment information and trade confirmations will be made electronically, and by opening an HSA Investment Account I consent to the electronic delivery/access of all documents of any issuer whose securities are made available to my HSA, including issuers and securities made available after the date my account is opened.

Important Information Regarding Substitute W-9 Certification

Under penalties of perjury, I certify that: (1) the Social Security Number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen (including a U.S. resident alien).

Important Information Regarding Fees

Any applicable fees shall be deducted from my account. Fees payable in connection with my HSA are set forth on the attached fee schedule.

Important Information Regarding Custodial and Investment Information

I have read and understand the HSA Custodial Agreement and Disclosure Statement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

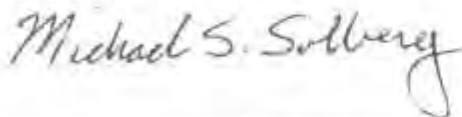
- a. determining that I am eligible to make contributions to an HSA for each year I make a contribution;
- b. ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;
- c. the tax consequences of any contributions (including rollover contributions) or distributions; and
- d. seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

If I choose to select an investment allocation from the TPA's list of mutual funds, I will be solely responsible for direction of the investment of my HSA. I represent that I will carefully review investment information prior to making investment decisions and that I will seek assistance of a financial professional if I have questions about available investment options or how to select investments for my HSA.

I authorize Healthcare Bank, a division of State Bank & Trust, and its agents to initiate permitted transfers, including contributions, to my HSA, as directed by me or my Designated Representative through the electronic account service features or as otherwise permitted under this HSA. Any such direction shall remain in effect until Healthcare Bank and its agents receive notice of a change to such directions via the electronic account service features or as otherwise permitted under this HSA.

I certify that the information provided by me on this Enrollment Form is accurate, and that I have received a copy of the enrollment form and HSA Custodial Agreement and Disclosure Statement and amendments thereto. I assume sole responsibility for all consequences found in the Enrollment Form and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Healthcare Bank, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Healthcare Bank harmless against any and all claims or losses arising from my actions.

I hereby further agree to designate the TPA to serve as my Designated Representative with respect to my HSA account. By signing below I agree to be bound by the terms and conditions of the separate agreement entitled Designation of Representative by HSA Client and by my signature each party respectively acknowledges his or her understanding and agreement with such terms and conditions.

Signature of HSA Account Holder

Date

Authorized Signature of Healthcare Bank as Custodian



Health Savings Account Direct Deposit Authorization Form
<i>Please complete and sign for convenient Automatic Deposit Option with E-mail Notifications. Please note that an <u>Email address</u> is required to enroll in Automatic Deposit.</i>
Employer Name:
Employee Name:
Social Security #:
Address:
City, State, Zip:
SIGNATURE:
Email address:

Please attach a voided check or a copy of a voided check and fill in the information below. Please check closely for accuracy.

Bank Routing Number (9 digits)
Bank Account Number



COMPLETE, SIGN, AND RETURN TO:

**Conservation Employees' Benefits Plan
PO Box 507
Jefferson City, MO 65102-0507**



Group Term Life Insurance Beneficiary Designation

- This form **MUST** be signed before you return it. See "SECTION III – Signature" on page 3.

SECTION I - Insured Information

Customer Number 154218		Employer Name/Group Policyholder Name Missouri Dept. Of Conservation	
First Name	Middle Name	Last Name	
Address – Street	City	State	ZIP Code
Date of Birth	Phone Number ()	SSN	

SECTION II - Beneficiary Information

- You **MUST** designate at least one primary beneficiary. **A person may only be listed once.** Anyone listed in the primary section cannot be listed in the contingent section.
- The sum of the Primary Beneficiary percentages **MUST equal 100%**. The sum of the Contingent Beneficiary percentages **MUST equal 100%**. Dollar amounts, fractions and decimals will not be accepted.
- If you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Please complete the section that pertains to the type of beneficiary you are designating.

☐ A. Individual Beneficiaries

PRIMARY BENEFICIARY - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()	
First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()	
First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()	

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name		Middle Initial	Last Name		Share: %
Address - Street		City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		

First Name		Middle Initial	Last Name		Share: %
Address - Street		City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		

☐ **B. Living Trust** - ☐ Primary ☐ Contingent

If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name		Trust Date	Trustee Phone Number ()		Share: %
Trustee - First Name		Middle Initial	Last Name		
Trustee Address - Street		City	State	ZIP Code	

☐ **C. Testamentary Trust Created in the Insured's Will** - ☐ Primary ☐ Contingent

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

Share: %

☐ **D. Insured's Estate** - ☐ Primary ☐ Contingent

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

☐ **E. Charity/Organization** - ☐ Primary ☐ Contingent

Be sure to name the charity or organization and not the charity or organization director or an employee of that charity/organization.

Charity/Organization Name		Phone Number ()		Share: %
Address - Street		City	State ZIP Code	

SECTION III - Signature

- ☐ Check if you are completing and signing this form as agent for the employee under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section II as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured/Owner Name (Please Print)

Insured/Owner Signature

Date (must be date form was completed)



How to Submit This Form

The employee should provide the completed form to their employer or benefits administrator. Retain a copy for your records.

Please note: You MUST return all pages of this form.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I. Information About the Use or Disclosure

I hereby understand that the Conservation Employees' Insurance Trust Fund (the "Plan") may use and disclose protected health information ("PHI") about me for purposes of health care treatment, health care payment and health care operations without my authorization or opportunity to agree or object to the use or disclosure in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). However, I request to restrict use and disclosure of PHI concerning treatment, payment and health care operations about me, or to restrict disclosures to family members, relatives, friends or other persons identified by me who are involved in my care or payment for that care.

II. Plan Information

Department designee(s) within the Human Resources office to whom the "Plan" can disclose protected health information are: Compensation Manager, Human Resources Specialist, Human Resources Services Analyst and Human Resources Technician.

The Privacy Official is the Compensation Manager.

III. Password Protection

Would you like to have your account password protected? ☐

If yes, what would you like for your password?

IV. Disclosure Authorization

Please list the name of each organization or individual, outside of the personnel listed in Item II, to whom you would like the Department designees to disclose protected health information. (With respect to another business entity, indicate the name of business as well as the contact person.) Also, describe the type of information that you would like the Department designees to disclose to that organization or individual, i.e., *Betty Doe, All Information*. In addition, indicate the reason for the requested disclosure (you may simply state "at my request").

Name(s)	Information Department Designee(s) May Disclose/Reason Disclosure is Requested
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

If you need to add additional names, please list on a separate sheet of paper and attach to this form.

V. Special Instructions

Special instructions for handling confidential communications:

VI. Revoking of Authorization

This authorization will expire on: (indicate a date or an event relating to you personally)

Over

VII. Other Important Information

I have read and understood the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying the Conservation Employees' Insurance Trust Fund in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.

I may see and copy the information described on this form if I ask for it.

I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

VIII. Signature of Member or Member's Representative

(This form MUST be completed before signing.)

Signature of member or member's representative _____

Date _____

Printed name of member: _____

Printed name of member's personal representative: _____

Relationship to the member, including
authority for status as representative _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Notifications

ANNUAL NOTICES

Coordination of Benefits Verification

In the near future, you will receive a "Coordination of Benefits" form from HealthSCOPE Benefits asking members with family coverage to indicate whether their spouse is employed and offered health insurance coverage by their employer. Please be sure to complete and submit this form as instructed to prevent delays and problems in claims payments.

Notice of Compliance of Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21, 1998, amending the Employee Retirement Income Security Act of 1974 (ERISA). The law requires plans, which provide mastectomy coverage, to provide notice to individuals of their rights to benefits for breast reconstruction following a mastectomy. Your Plan currently provides coverage for a mastectomy and reconstructive breast surgery following a mastectomy.

Benefits for medical and surgical treatment for reconstruction in connection with a mastectomy are further clarified as follows according to the requirements of the Women's Health and Cancer Rights Act of 1998:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce symmetrical appearance; and
3. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient.

These benefits will be paid at the same level as other benefits payable under the Plan. CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2014. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	FLORIDA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
ARIZONA – CHIP	GEORGIA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: http://www.dhhs.nh.gov/oii/documents/hippap.p.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm	Website:

Phone: 1-800-635-2570	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OKLAHOMA – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

OREGON – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA – Medicaid	WYOMING – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://health.wyo.gov/healthcarefin/equalitycare
TEXAS – Medicaid	Phone: 307-777-7531
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	

To see if any more States have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

FAQ'S/GLOSSARY

FREQUENTLY ASKED QUESTIONS

Q. What opportunities do I have to add, cancel or change medical and/or life insurance coverage?

A. You may add, cancel or change medical and/or life insurance as follows:

- **Active Salaried Employee medical insurance coverage**
 - During the open enrollment period, you may enroll yourself and/or any eligible dependents in the medical plan effective January 1 of the following plan year.
 - You may enroll within 31 days of the occurrence of a life event – marriage or the birth/adoption of a child.
 - You may enroll within 31 days of a loss of medical insurance coverage.
 - You may cancel coverage or change your coverage tier during the annual fall enrollment period. Coverage changes are effective January 1 of the following plan year.
- **Active Salaried Employee life insurance coverage**
 - You may elect optional life insurance coverage during open enrollment with an effective date of January 1, 2015. You may increase your coverage by one level without providing medical information. Coverage levels exceeding one level will require an Evidence of Insurability..
 - You may enroll within 31 days of the occurrence of a life event – marriage or the birth/adoption of a child. Medical information may be required.
 - You may cancel coverage or decrease coverage during the annual fall enrollment period. Coverage changes are effective January 1 of the following plan year.
- **Retiree medical insurance coverage: The retiree must be covered on the Plan at the time of retirement in order to continue coverage or add coverage due to any of the occurrences below.**
 - You may enroll eligible dependents within 31 days of the occurrence of a life event – marriage or the birth/adoption of a child.
 - You may enroll eligible dependents within 31 days of a loss of medical insurance coverage.
 - You may cancel coverage at any time. **If coverage is cancelled, you may not enroll in the Plan at a later date.**
 - You may decrease your coverage tier during the annual fall enrollment period. Coverage changes are effective January 1 of the following plan year.
- **Retiree life insurance coverage**
 - You have the opportunity during the annual fall enrollment period to decrease your life insurance coverage. Coverage changes are effective January 1 of the following plan year.
 - You may cancel coverage at any time. **If coverage is cancelled, you may not enroll in the Plan at a later date.**

Q. What qualifies as a loss of coverage?

A. A loss of coverage would be:

- **If you are an Active Salaried Employee** and declined enrollment for yourself and/or your eligible dependents under the CEBP because of other health coverage, you may elect coverage for yourself and/or any eligible dependents if the other health insurance coverage is lost for reasons other than failure to make required payment. Loss of coverage may occur as a result of divorce, death, termination of employment (whether voluntary or involuntary), reduction in the number of hours worked, or employer contributions were terminated. Enrollment in the CEBP must be done within 31 days of the loss of coverage.
- **If you are a Retiree** covered under the CEBP and you declined enrollment for your eligible dependents because of other health coverage, you may elect coverage for any eligible dependents if the other health insurance coverage is lost for reasons other than failure to make required payment. Loss of coverage may occur as a result of divorce, death, termination of employment (whether voluntary or involuntary), reduction in the number of hours worked or employer contributions were terminated. Enrollment in the CEBP must be done within 31 days of the loss of coverage.

Q: If I do not submit the Tobacco-Free Attestation Form, what premium will I pay?

A: *If you do not submit the form, you will pay the tobacco user premium and will not receive the premium discount.*

Q: If I stop using tobacco during the Plan year, will I pay the tobacco user rate for the entire year?

A: *No, if you complete a Tobacco-Free Attestation Form when you stop using tobacco, the non-tobacco user premium discount will apply.*

Q. Is the Tobacco Attestation retroactive?

A. *No, the discounted premium will apply the pay period following receipt of the completed form.*

Q. How does the family deductible work?

A. *To satisfy a family deductible, one family member must meet the individual deductible, and the remaining amount can be satisfied through the combination of all other out-of-pocket expenses by remaining family members. After the family deductible is reached, the deductible is satisfied for all covered family members during the remainder of the benefit period.*

Q. How long can dependent children stay on my medical plan?

A. *They are covered until the age of 26 whether they are married or unmarried. Children may be natural, step, adopted, foster or other children related to you by blood or marriage for which you have guardianship or custody. Children who are disabled prior to age 19, may remain on the Plan indefinitely as long as proof of disability is provided as specified in the SPD.*

Q. I would like to see a Specialist, do I need a referral?

A. *No, you do not need a referral from your Primary Care Physician to see a Specialist.*

Q. Is a shingles shot covered?

A. *Yes, the shingles shot is covered at 100%. There is no age restriction on when you may receive the shot.*

Q. How do I get reimbursed for my flu shot and/or shingles shot that I paid out-of-pocket?

A. *You may submit a medical claim form to HealthSCOPE Benefits. Reimbursement will be issued in the form of a paper check.*

Q. What should I consider before enrolling in the HDHP?

A. *You should consider your:*

- *Current medical costs - not just deductibles or coinsurance amounts - but how much your medical and pharmacy benefit plans pay on your claims.*
- *Ability to pay the annual deductible and out-of-pocket maximum should you or a dependent require high-cost medical care.*
- *Monthly premiums, sign-on contributions and Healthy Reward Incentives*

Q. Does the HDHP deductible count toward the out-of pocket maximum?

A. *Yes.*

- *If using an In-network provider, once you meet the deductible, the plan pays 100% of covered expenses.*
- *For out-of-network services, you pay 30% coinsurance after meeting the deductible until you meet a \$4,000 individual/\$8,000 family out-of-pocket maximum. Then the plan pays 100% of covered expenses.*

Q. Can I participate in my spouse's medical plan if I enroll in the HDHP?

A. *If you enroll in the HDHP, you cannot be covered under another medical plan **unless** it is another qualified HDHP.*

HEALTH SAVINGS ACCOUNT (HSA) – Active Employees Only

Q. What is a Health Savings Account (HSA)?

A. *It's a tax-advantaged medical savings account for people enrolled in an IRS-qualified High Deductible Health Plan (HDHP).*

Q. Can I contribute to the HSA if I'm no longer enrolled in the HDHP?

A. *No, you must be enrolled in a qualified HDHP to contribute toward the HSA.*

Q. What happens if I use the funds for non-qualified expenses?

A. *If funds are not used for qualified medical expenses, you are subject to taxes and a 20% penalty. No additional taxes or penalties apply to funds used for any purchase after the date you are disabled, reach age 65 or die.*

Q. If an employee and spouse are enrolled in the HDHP, is each person eligible for \$500 worth of Healthy Reward incentives?

A. *Yes, if both are enrolled in the HDHP, then the maximum amount of Healthy Reward Incentives that can be earned is \$1,000.*

Q. Are children eligible to earn Healthy Reward Incentives?

A. *No, only adults are eligible for the incentives.*

Q. Are there any tax consequences related to the \$250 sign-on contribution into my HSA or the healthy rewards incentives?

A. *No, there will not be any tax consequences as long as the total contributions to an employee's account (both MDC's and employees) do not exceed the federally allowed limits.*

➤ *The contribution limits for 2015 are as follows:*

- *Individual - \$3,350*
- *Family - \$6,650*
- *Catch-up contributions (55+) – additional \$1,000*

Q. If I am enrolled as "employee only" in the HDHP/HSA, can I use HSA funds to pay for eligible expenses for my family who are covered under another plan?

A. ➤ *If your family members are covered under a non-qualified plan (meaning they are not participating in an HDHP), then you may not contribute funds into an HSA at the family level.*
➤ *If your family members are covered under a qualified plan (HDHP) and another HSA does not exist, then you can in fact contribute to the HSA at the family level.*

Q. Can I use my HSA to pay my premium?

A. *If you are an active employee, you cannot use your HSA to pay premiums. The HSA can only be used to pay premiums if you are collecting unemployment or have COBRA continuation coverage through a former employer.*

Q. If I don't use the money in my HSA by the end of the plan year, does it go away?

A. *No, the funds in your HSA roll over into the next plan year if you don't use them.*

Q. What happens to my HSA account if I don't enroll in the HDHP again, retire, or leave MDC?

A. *The HSA belongs to you. If the money is not spent, it continues to grow. Whether you leave the HDHP plan or MDC, you may use HSA funds to pay for current or future health costs. It's up to you to decide what works best for you. However, if you are no longer enrolled in an HDHP, you cannot **contribute** money to the HSA.*

Q. What information will I receive next year to help file my taxes correctly?

A. *In January you will receive information from Healthcare Bank for filing your taxes:*

- *1099-SA with information on your distributions*
- *1099-INT with information on earnings*

Q. Can COBRA premiums be reimbursed from the account?

A. *Yes, distributions to pay premiums for COBRA are tax-free.*

Q. Is the account subject to COBRA continuation?

A. *No, but since an HSA is portable and owned by the employee, the individual may continue to use it after ending employment.*

Q. Is the annual amount of the contribution available on the first day of coverage?

A. *Only the amount contributed to date is available for reimbursement.*

Q. How do I keep track of my HSA funds?

A. *Healthcare Bank provides user-friendly web and phone tools for you to track activity and monitor the HSA's growth. You may access this information by following the Health Savings Account link on HealthSCOPE Benefits' website: www.healthscopebenefits.com or (877) 385-8775.*

Q. Can my spouse be on my account or access it?

A. *The HSA can only be established as an individual account, but you can assign your spouse to have Power of Attorney on the account. If Power of Attorney is established, your spouse can access the account. Also, you can use funds from your HSA to cover eligible medical expenses for your spouse and/or dependents. For maximum savings potential, both you and your spouse should have an HSA. This way, each of you can make catch-up contributions when you turn 55.*

Q. What happens to my HSA when I turn 65?

A. *You can continue to use the account tax-free for eligible out-of-pocket expenses. When your Medicare coverage takes effect, your HSA can take care of Medicare premiums, deductibles, and copays. At this age, you can also use HSA funds for non-medical reasons. The amount withdrawn is taxable as income, but it is not subject to penalties.*

Q. What happens to my HSA when I die?

A. *If you are married and your spouse is a named beneficiary, he or she becomes the owner of the account and assumes it as his/her own HSA. If you are unmarried, your account will cease to be an HSA. It will pass to beneficiaries or become a part of your estate, and it is subject to applicable taxes.*

Q. What is the difference between a Flexible Spending Account and a Health Savings Account?

A. *The Flexible Spending Account (FSA) is a state-sponsored benefit program that allows active employees to use pre-tax money to pay for certain medical expenses. Active employees may make pre-tax contributions to the FSA through MOCafe. These contributions are set up via payroll deduction each year, and the member can start drawing the entire year's contribution on February 1st. If the funds are not used by the end of the year, the member is not able to use the funds at a later date. If you enroll in the Health Savings Account (HSA) you cannot have a FSA.*

The Health Savings Account (HSA) is a bank account that you set up through Healthcare Bank to help pay for medical expenses. Only those enrolled in the High Deductible Health Plan may set up an HSA. In addition, you can also decide to contribute to the account until the total amount in your HSA reaches the maximum set by the IRS. Members can elect to make these contributions pre-tax via payroll deductions through MDC. The funds must be in the account to use them for medical expenses. There is no time limit on when funds must be used, and they go with you at retirement or with a job change.

Q. What preventive services are covered by the Plan?

A. *Under the CEBP, you and your family are eligible for a number of preventive services. Whether you are enrolled in the Traditional Medical Plan or the High Deductible Health Plan, these services are available at no additional cost to you or your family. You and all covered persons on the Plan have access to preventive services such as:*

Routine/Well Care for Adults: *Services are limited to one time per calendar year*

- Routine physical examination
- Routine gynecological exam
- Routine pap smear screening
- Routine PSA screening
- Routine digital rectal examination (DRE)
- Routine or diagnostic colonoscopy
- Bone Density scan
- Skin Cancer Screen
- Routine mammogram screening
- All diagnostic laboratory (biometric screening) examinations in connection with the physician office visit including a complete medical history, complete blood count (CBC), blood chemistry, urinalysis, pulmonary function, chest x-ray, EKG and immunizations
- Routine immunizations including:
 - Hepatitis shots
 - Flu shots & Flu mist
 - Pneumovax
 - Tetanus shots
 - Shingles shots

Routine/Well Care for Dependent Children: *Services are limited to one time per calendar year*

- Routine physical examination
- Routine immunizations
- All diagnostic laboratory examinations in connection with the routine physician office visit, including those screenings mandated by the State of Missouri for newborn screening requirements for potentially treatable or manageable disorders (e.g. Cystic Fibrosis, amino acid disorders, etc.), lead poisoning screenings and newborn hearing screenings.

GLOSSARY OF TERMS

Biometric Screening- An important component of a comprehensive health and wellness program. It measures blood pressure, cholesterol levels, triglycerides, blood glucose, and Body Mass Index.

Case Management- a voluntary program designed to inform patients of more cost effective settings for treatment. Case Management typically applies when an individual has a chronic or ongoing condition, or a catastrophic condition, that is expected to result in significant claim costs. All requests for Case Management will be individually reviewed by the Plan.

Catch-up Contribution - If you are 55 or older, the IRS allows you to deposit additional funds each year to help account “catch up” before retirement toward your HSA account.

CEBP – Conservation Employees’ Benefits Plan

Coinsurance – Means a percentage of the provider’s allowable charge that the plan pays for eligible expenses after the covered person’s deductible has been satisfied. The remaining percentage of the provider’s allowable charge is paid by the covered person. This percentage of the provider’s allowable charge paid by the covered person is referred to as the covered person’s coinsurance.

Copayment – Means the dollar amount payable by the covered person for a service, treatment or procedure rendered. The copayment is applicable on a per occurrence basis. The copayment shall continue to apply after the deductible has been satisfied and after the out-of-pocket maximum has been satisfied.

Customary and Reasonable (C&R) - If you seek care from an out-of-network provider, you are responsible for any charges above what is considered “customary and reasonable.” A customary and reasonable (C&R) charge is the amount determined as the normal range of payment for a specific service, treatment or supply in a given geographic area. You are responsible for paying the amount above the C&R rate.

Deductible – Means the amount a covered person must pay for eligible expenses incurred in a benefit period before benefits begin to be paid for that person under the Plan.

When applicable, an individual deductible is the amount that each covered person must pay during a benefit period before benefits begin to be paid for that person.

A family deductible is the maximum amount that two (2) or more family members covered under the same family coverage must pay in deductible expense in a benefit period. Under the family deductible, one (1) family member must satisfy an amount equal to the individual deductible, while eligible expenses for all other family members are used to satisfy the remaining portion of the family deductible. Once the family deductible is reached, eligible expenses incurred with a future date of service within the benefit period will not be subject to the deductible and the deductible is considered satisfied for all family members under that family coverage during the remainder of the benefit period.

Disease Management Program- A voluntary program used to evaluate medical and prescription claims to assess a participant’s risks and gaps in care. Health coaches assist participants with optimizing care guidelines respective to their general health and wellness and those specific to their chronic condition. As part of the program, an extensive initial assessment is conducted, followed by ongoing periodic condition specific assessments. A complete assessment is then conducted annually and changes in risk level are identified. The chronic conditions focused on as part of the Disease Management program are: Asthma; Diabetes (Type 1 and Type 2); Heart Health Conditions including Coronary Artery Disease, Hypertension,

High Cholesterol, Stroke, Cerebral Vascular Disease, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.

FN/FNS – Freedom Network/Freedom Network Select - The network of Preferred Providers to which the Covered Persons will have access under this Plan.

Health Savings Account (HSA) (*active employees only*) – A tax-advantaged savings account that may be used to pay current or future qualified medical expenses. An HSA is designed to work with an IRS-qualified high deductible health plan. HSA funds can be used to help pay the deductible, coinsurance and any qualified medical expenses not covered by the health plan.

High Deductible Health Plan (HDHP) – A high deductible health plan (HDHP) has higher deductibles than a traditional health plan. When combined with an HSA, an HDHP provides a tax-advantaged way to help save for future medical expenses.

HealthLink HMO Network – The network of Preferred Providers to which the covered persons will have access under this Plan.

HealthLink PPO Network – The network of Preferred Providers to which the covered persons will have access under this Plan.

In-network – Refers to covered services rendered by a Preferred Provider in the HMO Network, PPO Network, Freedom Network Select or Freedom Network.

Out-of-Network - Refers to covered services rendered by a Non-Preferred Provider.

Out-of-Pocket Maximum: An out-of-pocket maximum is the most that you should have to pay for your healthcare during the plan year. Before reaching the out-of-pocket maximum, you pay for part of your medical care, such as copays, coinsurance and deductibles. Once you have paid the amount set by the out-of-pocket maximum, your insurance will pay 100% of the allowed amount for your covered healthcare expenses.

Pre-Certification - Means a determination of Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g. appropriate length of stay or the appropriate number of visits or treatments).

Pre-Cert Penalty – If the member fails to follow the pre-certification guidelines as set forth in the SPD, payment of benefits for hospital expenses and certain services are reduced by \$200 penalty.

Preventive Service- Routine health care that includes check-ups, patient counseling and screenings to prevent illness, disease and other health-related problems. These services are provided at no cost to you, meaning that you will not have to pay a copayment or coinsurance or meet your deductible to receive them.

Primary Care Physician (PCP) – A physician in family medicine, general medicine, internal medicine, pediatrics, and obstetrics and gynecology.

PSA/DRE Exam- Prostate Specific Antigen and Digital Rectal Exam are tests for males to evaluate for the risk of cancer.

SPD – Summary Plan Document which is the written document, as adopted by the Plan Administrator, that sets forth the Plan's terms and conditions.

Traditional Plan – A plan in which the insured must pay a deductible before benefits become payable. After the deductible is met, the insurance company and the member share the cost of a service called coinsurance. In addition, the member pays a flat fee for each office visit, prescription, etc., called a copayment, which is applicable to the deductible and out-of-pocket maximum.

